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Nos. 91-744 and 91-902

Supreme Court, U.S.
FILED
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OFFICE OF THE CLERK

IN THE

Supreme Court of the United States

OCTOBER TERM, 1991

PLANNED PARENTHOOD OF SOUTHEASTERN PENNSYLVANIA, REPRODUCTIVE HEALTH AND COUNSELING CENTER, WOMEN'S HEALTH SERVICES, INC., WOMEN'S SUBURBAN CLINIC, ALLENTOWN WOMEN'S CENTER, and THOMAS ALLEN, M.D., on behalf of himself and all others similarly situated,

Petitioners and Cross-Respondents,

—v.—

ROBERT P. CASEY, ALLAN S. NOONAN, and ERNEST D. PREATE, JR., personally and in their official capacities,

Respondents and Cross-Petitioners.

ON WRITS OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE THIRD CIRCUIT

JOINT APPENDIX
VOLUME II

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The following opinions and orders have been omitted in printing this Joint Appendix because they appear on the following pages in the Appendix to the Petition for a Writ of Certiorari in No. 91-744.

Planned Parenthood v. Casey, 947 F.2d 682
(3d Cir. 1991) 1a

Planned Parenthood v. Casey, 744 F. Supp. 1323
(E.D. Pa. 1990) 104a

Order of the United States District Court
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EXCERPTS FROM DEFENDANTS' TRIAL EXHIBITS

Defendants' Exhibit 1: Excerpts from Magee-Womens Hospital Informed Consent for Termination of Pregnancy Form

MAGEE-WOMENS HOSPITAL
Pittsburgh, PA 15213
INFORMED CONSENT FOR TERMINATION OF PREGNANCY

I hereby authorize _____, M.D., and/ or such associates and assistants as he/she may select and supervise to perform the following procedure(s): _____.

The doctor has explained to me the nature and purpose of the procedure(s), the risks associated with the treatment, the available alternatives and risks of these alternatives, as summarized below.

1. The medical procedure to be used is _____, which has been explained to my full satisfaction.

2. The risks involved with the procedure(s) include severe blood loss, infection, perforation, incompleteness, possible need for further surgery (hysterectomy, removal of tubes and ovaries), possible sterility, danger to subsequent pregnancies, fatality and _____, which have been explained to my full satisfaction.

3. I understand that possible alternatives to the abortion procedure include childbirth and possible placement for adoption which have been explained to my full satisfaction. I fully understand the risks of these alternatives, which have been explained to me.

4. I fully understand that there is no guarantee that this procedure will be successful or that it will terminate my pregnancy.

5. If any unforeseen condition arises in the course of the abortion which, in accordance with good medical practice calls for procedures in addition to or different from those contemplated, I further authorize the above-named physician or his designee to perform such procedures which in his professional judgment are necessary.

6. I understand that it is my responsibility to bring to the attention of the staff physician and Magee-Womens Hospital any unusual symptoms following the procedure and to report for check-ups or pregnancy tests as recommended.

7. I have had full opportunity to ask additional questions of the doctor(s) and staff about this procedure and the risks and alternatives involved and am satisfied with the answers. I have no further questions. I understand that I am free to withhold or withdraw my consent to perform this procedure at any time prior to the abortion without prejudicing my future care.

8. I understand that Pennsylvania law requires that fetal tissue removed during an abortion be submitted for pathological examination.

Magee-Womens Hospital will be responsible for fetal tissue:

_____ Yes _____ No

I certify that I have read (or had read to me) and fully understand the above consent to abortion and the explanations referred therein were made to me.

_____ _____ _____

PATIENT SIGNATURE DATE TIME

PATIENT IDENTIFIED PRE-OPERATIVELY BY:

_____

* * *

Defendants' Exhibit 2:
Excerpts from Women's Health Services (WHS)
Individual Counseling Guidelines/
Post Abortion Group Guidelines/
Personal Counseling Guidelines

INDIVIDUAL COUNSELING GUIDELINES
Abortion Clinic

The purpose of this interview is to establish that the woman understands her pregnancy options and desires an abortion, has a genuinely informed consent, and to obtain the necessary history for the medical record.

Before the interview the counselor should review the chart, looking for LMP, any pelvic exam, age, distance traveled, occupation, whether anyone is accompanying her, marital status, medical history, record of prior visits and lab work. This information is helpful to have in mind when greeting and getting to know the woman so that we can provide service in a manner that will meet her needs as well as those of the people accompanying her.

The usual interview covers steps 1 thru 14 of the outline below and takes from ten to thirty minutes. The average time is about twenty minutes but can vary due to specific circumstances. In this interview the counselor must assess the woman's individual needs and determine the best way to organize the session. Women who are conflicted and unable to resolve those conflicts in a short period of time (15 minutes) should be referred immediately to the personal counselor or to a counseling administrator.

There are times when all information given to the patient including the post abortion follow up instructions

and the contraceptive instructions should be done in the individual session. Women who are deaf, have significant English language problems, adolescents under 15, those who are slow to comprehend, or who have emotional disabilities should be given all information in this individual session. The latter paragraphs below describe the steps in covering this additional information.

Suggested interview outline:

1. Give an overview of what the woman will experience during her stay--where she will be, how long she will be in certain places.

2. Tell the woman what you will be talking about during the interview and that you will (1) discuss any questions or concerns the woman has about the abortion (2) discuss the procedure (3) take her medical history. In this way a contract is informally set. It is important that the woman knows what to expect from the counselor during the interview--that the goals are clearly defined. For those who are to have all information individually the counselor would also include (3) care afterwards and (4) birth control in her overview of the interview.

3. Encourage the woman to ask any questions she may have. She will be more *ready* to listen if this is done first. Find out what she knows about the abortion procedure. Her questions, level of information and concerns will help the counselor gauge where to start. It is up to the counselor to decide in what order to cover the necessary information with the woman so that it attends to those individual needs that are within the limits of the counselor's goals and capabilities.

4. The counselor usually describes the procedure next, reviewing each step and what the patient will feel. The counselor starts by making certain that the woman understands basic reproductive anatomy and the menstrual cycle.

5. The complications should be listed and an explanation of how they might occur. These must be presented in a way that is both realistic and in perspective to the chance of occurrence. We believe a genuinely informed consent should be part of any medical procedure. All patients should have infection, hemorrhage, perforation and incompleteness, the possibility of further medical treatment or surgery, i.e. hysterectomy, removal of tubes or ovaries resulting in sterility, as well as fatality explained to them. Emphasize that in an EA the most common complication is incompleteness.*

6. Assess the woman's readiness for the abortion by asking her if it was an easy or difficult decision, and with whom she has been able to discuss this. If the woman is not ready for the abortion, the counselor should stop here, attempt to help resolve the issues and get help from the personal counselor or supervisor if needed. The counselor should make sure that the woman understands all the options available to her including abortion or a full term delivery where she could either keep the child or put it up for adoption.

7. Take the histories on pages 1, 2, 3, 4, 5 of the chart.

8. Take her vital signs and record them.

9. Have her read or read to her the consent. Have

patient sign the consent. Witness the consent.

10. All women should be given a copy of the WHS "Guide to Birth Control Options" and asked to look it over in preparation for the recovery group.

11. When the interview is finished, allow the patient to stay in the counseling room, and take the chart to the lab for the test results.

12. If the blood type is Rh Negative explain the meaning of this before you escort her from the counseling room.

13. Get and record her weight, instruct her to use the restroom if possible and then have a seat in the waiting area.

14. Counselor should take her completed chart to flow and get her next assignment.

If the patient is to receive all information on an individual basis the counselor will:

A. Review all information on the post abortion instructions* after completing the histories in step 7. The attached envelopes should be reviewed also.

*The EA patient will be given additional instructions in the Recovery Room. Tell her in counseling that if the fetal tissue is less than 8 weeks LMP, she will need a pregnancy test within 2 to 3 weeks after the abortion as well as a check-up by 8 weeks. She should make her check-up appointment after getting her

pregnancy test results. For a check-up made after 8 weeks the woman will be charged for an annual exam. Tell the patient that on the slight chance she is still pregnant at the time of the UCG, it is important that she have a repeat procedure to terminate the pregnancy. The fetus can be damaged by infection from the uterus having been entered.

B. The review of the birth control methods is done next. The goals are to give accurate birth control information, assess the woman's needs for a method and usually urge the woman to choose a method to prevent further pregnancies. The counselor gives a brief introductory overview to all the methods, and then, depending on how the woman responds, discusses all, one, or several of the methods. Each woman is instructed in the use of foam and condoms since it is an easily available back-up method. If a woman states she does not plan to use any, this is explored--complete information on birth control is given so that she will know about the methods for the future. If she does not want a method, that decision is respected.

C. Complete steps 8 and 9.

* * *

Summary of Charting Inservice

5. Specific charting areas

a. *Page One* will no longer be reviewed in depth by the receptionist. This will now be the

counselor's responsibility. Clerical will cover the "black dot" questions (allergies, heart, epilepsy, seizures, diabetes, hepititis, jaundice) and the "white dot" data needed for sizing in order to make the necessary referrals to the NP/PA's.
The counselor covers items 1-36 recording for any circled items: date of occurrence and description (original onset, degree of problem, treatment if any). Counselor covers any medication taken today, medications taken previously, any allergies and allergic reactions to medicines. The allergies are circled in red on page one and the counselor writes the allergy in red on page 5 on allergy line. Remember to write N/A at any section where there is nothing to record to indicate you covered the data.

The counselor should review any questionable histories with NP/PA's to determine if any special exam or care is necessary.

Counselor must be fully aware of the contraindications to abortion in Medical Standards.

b. *Page 2* - It is important to record what isn't as well as what is (birth control history -- none used for example). The counselor checks the appropriate box in the laboratory section when VD culture is done in procedure.

c. *Page 3* - The counseling paragraph should summarize *Relationship issues* (a stress situation, how partner, parents, friends, others of significance have responded to decision, degree of support wanted and available, how do parents and/or partner see their emotional and financial responsibility to patient; *ability to communicate* (any need for special explanations due to

language problems, slowness); *the decision* (difficulties, pros and cons, reason for termination, any issues concerning morality of abortion). If the woman is having the abortion for medical reasons this must be stated and that the option of a second opinion with genetic counseling was offered must be recorded.
Special Cases 1) Reasons for not telling parent if underage, 2) If patient is victim - raped or incest - and on MA it must be recorded in counseling paragraph as the reason for the abortion, 3) If full interview done and reason for doing this is to be recorded.

The counseling paragraphs should be written in complete sentences, no slang should be used, be descriptive, discreet and avoid the counselor's personal judgments about the patient or her life style. The paragraph should only summarize information related to the abortion decision.

All pamphlets given to her, referrals to personal counselor, other referrals such as to PAAR, Neighborhhod Legal Services, etc. should be recorded under recommendations and referrals.

When a patient is voided, the administrator should record the related information in the box on the bottom of page 3 so we can use the same insert if the patient returns for termination of that pregnancy.

PERSONAL COUNSELING SESSION

Interviewer: _____ Case#_____
(Initials) (If appropriate)

Nickname: _____ DOB:_____

INTRODUCTORY COMMENT: I understand that you've been having a difficult time with this decision. Perhaps by talking about your concerns and hearing the answers to your questions, you will be better able to decide what is best. Our discussion is intended to be of help to you. Any time you don't understand why I'm asking a particular question, please feel free to ask me about my reasons for asking that particular question.

INTERVIEW QUESTIONS:

1. When you think of pregnancy, what kinds of things come to mind?

_____
_____
_____
_____

2. How long have you been pregnant?_____

3. Have you ever had an abortion? ___No ___Yes
(Number:___)

4. Who have you chosen to tell about your pregnancy?
People* told. Their reaction

_____

* This person accompanied patient.

_____
_____
_____
_____

Partner's reaction to pregnancy - initially:
__Positive __Negative __Not Told

_____'s current reaction is: __Positive __Negative
(Name of Partner)

_____
_____

5. What were your beliefs about abortion before this happened?
__AB acceptable
__AB acceptable, difficult decision
__AB unacceptable, unless under cases of rape, incest, MR, etc.
__AB unacceptable
Comment: _____
_____
_____

6. Do you have other children? __Yes __No

7. How do you see a child fitting into your life right now?

_____
_____
_____
_____

8. What is your religious background?
__Christian __Jewish __Moslum __Catholic
__Protestant __N/A

9. Have you ever been hospitalized for a nervous disorder? __No __Yes Where?

_____

10. Have you ever seen a counselor, psychologist, psychiatrist? __No __Yes

11. Do you have any questions of me?
__ No
__ Client asked about procedure.
__ Client asked about fees.
__ Client asked about feelings women have post AB.
__ Client asked if the procedure will affect future pregnancies.
__ Other (specify) _____
_____
_____

CLIENT ORIENTATION DURING INTERVIEW

Internal Control . . . . . External Control

Little Denial Present . . . . . Denial Evident

Self Esteem Present . . . . . Poor Self Esteem

INTERVENTIONS

__ Support for assertive right to make personal choice, whether AB, pregnancy to term, adoption.
__ Showed pictures of early fetal development.
__ Gave reading materials.
__ Gave list of phone numbers related to religious

groups/individuals (client may contact)

___ Cognitive restructuring to establish fact(s)/realty related to _____

_____

_____

RECOMMENDATIONS

___ None needed/none requested

___ Client is comfortable with her current personal choice.

___ Suggested she give AB more thought.

___ Client is to return to another session on (date) _____

___ Client is to return for another session "when needed"

___ Contact West Penn Hospital for genetic counseling/information

___ Call for sizing appointment

___ Suggested she seek support from significant other(s). Specify _____

_____

_____

___ Suggested she return for post AB session.

___ Suggested that AB doesn't appear to fit within her value system. We discussed other options for a second time.

OTHER RECOMMENDATIONS not aforementioned

_____

_____

CLIENT DECISION

___ Keep scheduled appointment for procedure
___Very comfortable with decision
___Comfortable with decision

___ Schedule procedure
___Very comfortable with decision
___Comfortable with decision

___ Schedule another personal counseling session

___ Give procedure further thought

___ Discuss potential decision with significant other(s)_____

_____

___ Keep Pregnancy

___ Adoption procedure (___gave information on local adoption agencies)

INTERVIEW QUESTIONS WITH PERSON(S) ACCOMPANYING CLIENT

___ Not applicable, no one accompanied her

___ Mother ___ Relative (Specify_____)

___ Father ___ Friend

___ Partner ___ Counselor

1. What are your thoughts regarding this pregnancy?

_____

_____

_____

_____

2. How long have you known about this pregnancy? ___

3. Who else have you told?_____
Does the client know this? ___Yes ___No

4. What are some of your concerns?_____

_____

_____

5. In what areas are you willing to be helpful if she decides to carry her pregnancy to term?

___ Emotional support, no matter what she decides.
___ None, she's on her own.
___ Lodging, she can live with me/us
___ Child care (full time/part time/occasionally)
___ Financial
___ Just food for she'll be on her own
___ Other (specify) _____

6. Have you told her how much support/help she can expect from you? ___Yes ___No
(If "no", when do you plan to do so? _____)

7. Do you have any questions of me?
___ About the procedure
___ Fees
___ AB effect on future pregnancies
___ Other (specify) _____

8. Interview's impression of significant others. Check (✓) all that apply.
___ Opinion seeker
___ Initator (person is appropriately assertive)
___ Information seeker
___ Opinion giver
___ Information giver
___ Elaborator
___ Organizer/coordinator
___ Evaluator/critic
___ Aggressor
___ Blocker (person avoids reality of situation)
___ Moralizer
___ Supporter
___ Passive
___ Observer
___ Follower
___ Compromises

___ Harmonizer
___ Recognition seeker
___ Self-confessor
___ Dominator
___ Help seeker

RECOMMENDATIONS TO SIGNIFICANT OTHER(S)

Not needed, already present	Needed	
___	___	Offer emotional support, no matter what she decides.
___	___	Make position clear to client
___	___	Seek counsel from other sources, e.g., _____
___	___	Return with client for another session
___	___	Stop enabling client's excessive dependency
___	___	Read the same material given to client so topics can be discussed.

Comments: (please use reverse side)

Defendants' Exhibit 3:
WHS Consent for Abortion Form

CONSENT FOR ABORTION

I hereby authorize a Staff Physician to perform upon me a VACUUM ASPIRATION ABORTION, including all the mechanical aspects, which have been explained to me.

I consent to the administration of anesthesia to be applied by or under the direction of the staff physician, and the use of such anesthetics as s/he may deem advisable.

If any unforeseen condition arises in the course of the abortion which, in accord with good medical practice, calls for procedures in addition to or different from those contemplated, I further request and authorize the staff physician to perform such procedures, or administer any medication which s/he may deem advisable or to have me admitted to a hospital facility.

I understand that it is my responsibility to bring to the attention of Women's Health Services, Inc. any unusual symptoms following the abortion and to report for check-ups or pregnancy tests as recommended.

The nature and purpose of an abortion by vacuum aspirations, other abortion techniques, and the alternatives to abortion, including childbirth and adoption, the risks involved, and the possibility of complications and detrimental physical and psychological effects which are not anticipated but may occur, including by way of illustration and not limitation, hemorrhage, infection, perforation, incompleteness as well as the possible need for further surgery (i.e. hysterectomy, removal of tubes and ovaries), possible sterility and fatality, all of which have been fully

explained to me.

I authorize Women's Health Services to dispose of all fetal tissue as it sees fit.

I CERTIFY THAT I HAVE READ (OR HAD READ TO ME) AND FULLY UNDERSTAND THE ABOVE CONSENT OF ABORTION AND THAT THE EXPLANATIONS THEREIN REFERRED TO WERE MADE.

Date_____ Time_____
Signature of Patient _____

_____
Signature of Person authorized to give consent, if not patient

_____
Relationship to Patient

_____
Signature of Physician

_____
Signature of Witness

_____

ECTOPIC PRECAUTIONS

I certify that I have received a copy of the sheet listing the precautions for possible ectopic pregnancy, have read it and understand the importance of the medical follow-up.

Date____ Signature of
Patient _____

_____

Alternate contact person in addition to myself:

_____

Relationship Phone Number

_____

Signature of Witness

_____

EARLY ABORTION SPECIAL INSTRUCTIONS

I certify that I have received a copy of the sheet describing the special instructions for early abortion patients, have read it and understand the importance of the medical follow-up.

Date____ Signature of
Patient _____

_____

Signature of person authorized to give consent, if not patient

_____

Relationship to Patient

_____

Signature of Witness

_____

POST ABORTION INSTRUCTIONS

I certify that I have received a copy of the sheet describing instructions for after the abortion, have read it and understand the importance of the medical follow-up.

Date____ Signature of
Patient _____

Signature of
Witness _____

_____

Signature of Person authorized to give consent, if not patient

_____

Relationship to Patient

_____

CONSENT FOR ORAL CONTRACEPTION

I hereby authorize a staff physician of Women's Health Services, Inc. and/or whomever s/he may designate as a practitioner to perform:

Contraceptive Services and Supplies

I have received and agreed to read the patient information on oral contraceptions provided by the manufacturer.

I do hereby release Women's Health Services, Inc. from any and all claims which I may have by reason of their providing me this service.

I understand that it is my responsibility to bring to the attention of Women's Health Services, Inc., any unusual symptoms and to report for check-ups as recommended.

I CERTIFY THAT I HAVE READ (OR HAD READ TO ME) AND FULLY UNDERSTAND THE ABOVE CONSENT TO CONTRACEPTIVE SERVICES AND SUPPLIES, AND THAT THE EXPLANATIONS THEREIN REFERRED TO WERE MADE AND THAT ALL BLANKS OR STATEMENTS REQUIRING INSERTION OR COMPLETION WERE FILLED IN.

Date____ Signature of Patient _____

_____

Signature of person authorized to give consent, if not patient

_____

Relationship to Patient

_____

Signature of Witness

_____

_____

I do hereby release Women's Health Services, Inc. from any and all claims which I may have by reason of their providing me this service I understand that it is my responsibility to bring to the attention of Women's Health Services, Inc., any unusual symptoms and to report for check-ups as recommended.

Date____ Gynecological Exam

Signature of Patient _____

Date____ Antibiotic Therapy

Signature of Patient _____

Defendants' Exhibit 4:
WHS November 20, 1986
Memo Re Parental Notification

To: All Paraprofessional Counselors, Nurse Counselors, Clerical Staff, Administrative Staff, Personal Counselors

From: Liz Lincoln

Date: November 20, 1986

RE: Addition to 11/23/86 memo regarding parental notification

Please re-read the 11/23/86 memo. A copy is on the staff lounge bulletin board for convenience.

While we are not going to ask parents to come in when we make an appointment for an adolescent, if a parent or parents come in on the day of the abortion we will get their signature on the consent page of the chart using the following guidelines.

1. Front Reception - Ahead of time, identify which patients on the appointment list are less than 18 (up to day before 18th birthday). When the adolescent signs in, ask if anyone has accompanied her. If a parent or parents are there, instruct her to tell them not to leave the facility until they are notified the abortion is done.

2. Counselors - Nurse/Counselors - After greeting the patient who has parents here give her an overview of the counseling interview and ask if the parent can sit in on the description of the abortion and the

complications so the parent can sign the part of the consent for "others authorized to give consent". Most should agree if this is presented as described below.

Try to include just one parent - although if both want to come we should accommodate that. Use one of the four rooms with windows since those rooms are larger. Extra chairs will be put in scale room for you to use and return when needed.

Review the procedure, possible complications, and options to abortion with the parent and adolescent. Answer questions. Give reassurance if needed. Get parent's consent on line titled "signature of person authorized to give consent, if not patient". Write parent on line titled "relationship to patient". Escort parent back to front waiting areas. The patient herself will sign on "Signature of patient" line after the interview is completed. Counselor witnesses at that point.

If the adolescent seems ambivalent, her decision making process and support system should be discussed before bringing the parents in, rather than after they are returned to the waiting area. Any conflicts about the decision should be resolved before including the parent.

If the patient does not want to include the parent, one of the counseling administrators or another counselor if available will cover the information with the parent and get the parent's signature.

This instance should be rare. The discussion of the decision, and support system, the history taking, vital

signs, etc. will always occur without the parents. If this is made clear and if the adolescent wants to be here, it will be all right with most of them to include the parents for the description of the procedure and complications.

If a separate discussion is needed for parent consent use separate consent sheet to expedite time and staple to original consent. Review procedure, complications, and options with parent.

We are doing this to comply with our liability insurance requirements. This is not part of the abortion control act.

REMINDER: After the procedure is done, the counselor accompanying the adolescent through procedure should see parents and tell them they can go out for an hour at that time if they wish. Give estimated discharge time.

Defendants' Exibit 5:
Excerpts from WHS Patient Record Form

WOMEN'S HEALTH SERVICES, INC.
PATIENT RECORD

Name _____
Address _____
City _____ County _____
State _____ Zip Code _____
Home Phone (____) _____
Business Phone (____) _____
_____
_____
Date of Birth _____ Age _____
___Single (Never Married) ___Married
___Widowed ___Separated ___Divorced
Name you wish to be called by _____
Occupation _____
Place of Employment _____
Referred to WHS by: _____
What is your doctor's (clinic's):
Name _____
Address _____
Telephone Number _____
(Area Code)
_____
_____

First Day of last normal menstrual period:
1._____ 4._____
2._____ 5._____
3._____ 6._____

Do you consider yourself to be in good health: Yes No
Circle the number for each of the following you have or have ever had:

1. epilepsy or seizures
2. hepatitis or jaundice
3. heart disease
4. rheumatic fever
5. heart murmer
6. diabetes (suger)
7. sexually transmitted disease (gonorrhea, syphilis, herpes, chlamydia)
8. disease or surgery of uterus, ovaries or tubes
9. extopic (tubal) pregnancy
10. cesarean section
11. Pelvic Inflammatory Disease (PID)
12. cancer
13. vaginal infection
14. urinary tract/ bladder/kidney infection
15. asthma
16. fainting, dizzy spells
17. breast lump or tumor
18. high blood pressure
19. sickle cell disease
20. blood transfusion
21. anemia
22. bleeding tendency
23. chest pains
24. shortness of breath
25. nausea and/or vomiting
26. frequent headaches
27. migraines
28. double vision
29. varicose veins
30. blood clots (phlebitis)
31. swollen feet or ankles
32. leg cramps
33. smoking
34. ever been hospitalized overnight

Any Family history of cancer, diabetes, T.B., allergies, epilepsy, heart problems, high blood pressure?

WHO	WHAT
_____	_____
_____	_____
_____	_____

Have you taken medication, today:
__No __Yes, I took

Date	Medication	Time
Date	Medication	Time
Date	Medication	Time

_____

OPTIONAL: For Research Purposes Only
Religion _____ Ethnic Background _____
Education - Last Grade Completed _____

_____

List any other Allergies such as bee stings, eggs, etc.

_____

Place an (X) in the appropriate column for any medicines you have ever used or are allergic to:

USED		ALLERGIC
_____	Doxycycline	_____
_____	Aspriin	_____
_____	Penicillin	_____
_____	Tetracycline	_____
_____	Sulfa	_____
_____	Codeine	_____
_____	Demerol	_____
_____	Antibiotics	_____
_____	Tranquilizers	_____
_____	Sedatives	_____
_____	(Novocaine) local anesthetic	_____
_____	Rho gam	_____
_____	Dilantin	_____
_____	Anticoagulant	_____
_____	Other	_____

Description of Reaction _____

_____

_____

Patient Name _____ Patient Number___

HISTORY AT INITIAL VISIT:

Date: _____

MENSTRUAL HISTORY:

Age of onset ___ length of cycle ___ days of flow ____
Amount of flow: Scant Moderate Heavy
Amount of Discomfort: _____
Relieved by: _____

INTERNAL EXAM:
Ever had one: Yes No Date_____

PAP SMEAR:
Ever had one: Yes No Date_____
Date_____
Date_____
Date_____
Date_____
Date_____
Date_____

ANY ABNORMALITIES: Yes No Date _____
If Yes, explain _____

CONTRACEPTIVE

	Dates Used	Problem	Dates Used	Problem
Pill				
IUD				
Dia-phragm				
Foam				
Con-doms				
Other				

PREGNANCY: Give dates (month & year); sex, male or female. If Cesarean section, circle dates.

Live births				
Still births				
Now living				
Spon. AB				
Induced AB				
Where				
Types				
Total Preg-nancies				

Complications:
Birthweight over 10 lbs.
Ectopic pregnancies
Multiple pregnancies
RH infants (jaundiced)
Molar Pregnancies
Hemorrhage

Patient Name _____ Patient Number___

ABORTION COUNSELING

Date _____
Return Date _____
Time In _____ Time Out _____
Referred from _____
Counseling received there? Yes No

1. contraceptive
2. abortion & alternatives
3. personal

Was abortion an easy or difficult decision?
(If difficult, explain below)

Able to discuss decision with concerned others:
Yes No
(If no, explain below)

With her today:
1) Name _____
Relationship _____
2) Name _____
Relationship _____
3) Name _____
Relationship _____

Pregnancy Test
Date _____
Place _____
Positive Negative
Emergency Contact: _____
Describe Woman's Mood: _____

_____
_____
_____
_____
_____
_____

Have you ever had professional counseling?
Yes No
If yes, explain _____
_____
_____
_____
_____
_____
_____
_____

Contact between 9-4 Monday thru Friday at:
Number Place Letter /Other
Nickname "Shelly" Yes No /Address

Check appropriate box(es):
___ Woman understands and desires termination, appears to have no problems with this and should do well.
___ Abortion related problems
___ Other life problems

_____ _____
_____
_____
_____
_____
_____
_____
_____

_____

_____

Consent form signed Yes No

Physicians Signature _____

Counselor's signature _____

Interview Group Counselor's signature _____

Recommendations/Referrals _____

_____

Counselor's signature _____

RESCHEDULE/VOID INFORMATION,

Date _____

_____

Signed _____

[4]

_____

Patient Name _____ Patient Number___

PHYSICAL FINDINGS

Date_____BP___P___Temp___Hgt.___Wgt.___

Return date if applicable_____

BP___P___Temp___Hgt.___Wgt.___

LMP:_____ Weeks since LMP _____

Sizing_____ LMP Sonar results _____

Name_____NP/PA

SBE Prophalaxis ___Yes ___No

_____

_____

Comments:_____

_____

_____

_____

_____

Contraceptive Desired 28O.C. F&C_____

_____

PROCEDURE

Date:_____

Pelvic Exam: Describe Positive Findings

External Genitalia + - _____

Vaginitis + - _____

Acute Cervicitis + - _____

Adnexal Mass or Tenderness + - _____

Uterus: Estimated Uterine Size _____

_____

Weeks from LMP

Anterior Midposition Posterior

OPERATIVE REPORT: VACUUM ASPIRATION

Date_____

Sound_____cm Dilation to:_____Fr.

Cannula:_____mm KARMAN

Nesacaine 2% 12cc Carbocaine 1%_____cc.

Pitressin 2.5 units or 5 units

Other _____

Uterine exploration: curette forceps both

I.U.D. + - Molar Degeneration + -

Tissue Volume Small Mod. Large(for gest.)

Villi Seen + - Molar Degeneration + - ?

Fetal Age_____(Weeks from LMP by tissue exam)

Embryo/Fetus: + - Incomplete ?Complete

Probably Complete

Blood Loss:_____cc. Perforation + -

Tissue to Pathology + - Rush + -

Comment: _____

_____

_____

Complications + - (comment below)

_____

_____

Patient state during procedure: _____

Notes and Comments: _____

_____

_____

_____

ORDERS FOR RECOVERY AND DISCHARGE

Immune Globulin

___Yes ___No

Valium_____ I.M., P.O._____

Pitocin_____cc._____

Methergine 0.2mg. I.M._____

Methergine 0.2mg. P.O. 6 tablets/12 tablets

Doxycycline 200mg. P.O. _____

Other _____

28 day O.C. _____

Acetominophen 1000 mg. _____

Ibuprofen 400 mg._____

Other _____

Return for pregnancy test 2 weeks

___Yes ___No

Early Abortion Instructions

___Yes ___No

Extopic Precautions

___Yes ___No

The Standard Dilation and Vacuum Aspiration Technique was performed as stated above

Signed_____M.D.

Time in_____ Time Out _____

Procedure Counselor: _____

RECOVERY ROOM

Time of Admission_____AM/PM Date_____

Hour				
Blood Pressure				
Pulse				
Bleed-ing	N Sm Mod Hvy	N Sm Mod Hvy	N Sm Mod Hvy	N Sm Mod Hvy
Pain/ Cramps	N M M S	N M M S	N M M S	N M M S

Allergies: No Yes_____

Previous Medication

Dosage Route & Site Time By

1.

2.

RH Negative: Yes No

Immune Globulin Given: Yes No

RH Inf. and Card: Yes No

Lab Comments:_____

Medication Administered	Doasage	Route & Site	Time	By
1.Doxycycline	200 mg.	P.O.		
2.Ibuprofen	400 mg.	P.O.		
3.				
4.				
5.				

Medication Dispensed	Dosage	Amount	By
1.Methergine	0.2 mg.	P.O.	6 tablets/ 12 tablets 1q. 6 hours
2.Ampicillin	250 mg.	QID x 12 doses	
3.			

Contraceptive: 28-day O.C. Type/Amount _____
Given By _____
F&C Tubal Vasectomy Diaphragm Has Own/None
Insurance Form Completed: Yes No
MA Forms: Yes No
Post Abortion Instructions:
Instruction Sheet: Yes No
Contraceptive Instructions: Yes No
Can read thermometer? Yes No
Thermometer given Yes No
Check-up: WHS_____ Private M.D._____
Excuse needed for _____ Yes No
No. of days _____ Given: Yes No
Transportation:
Car Cab Bus Train Plane Walk
Other____
By Self With Family/Friend
Emotional Condition:
Interacts openly Composed Withdrawn Upset
Referred for Personal Counseling
Physical Condition:
No Problems Cramps: Mild Moderate Severe
Other_____

_____ M.D.
Time of Discharge _____ AM/PM
Signed _____ RN/LPN
Signed _____ RN/LPN

Patient Name _____ Patient Number___

REPEAT PROCEDURE/EMERGENCY CHECK

Date _____

Time of Admission

_____AM Repeat Procedure Recheck

_____PM Repeat Admission Pls. Circle

PREGNANCY TEST Positive Negative

Pelvic Exam: Describe Positive Findings

Vaginitis + - _____

Acute Cervicitis + - _____

Adnexal Mass or Tenderness + - _____

Uterus: Estimated Uterine Size _____

(Wks from LMP)

Anterior Midposition Posterior

Carbocaine 1%_____cc Pitressin 2.5 units/5 units

Dilation: Yes to ___Fr. No

Cannula: ___mm BERKLEY KARMAN

Material Aspirated _____

_____

Blood Loss: _____cc Perforation + -

Tissue to Pathology + - Rush + -

Comment: _____

_____

Complications: + - (comment below)

_____

_____

Patient state during Procedure _____

Notes and Comments _____

Impression: _____

_____

_____

Plan: _____

ORDERS FOR RECOVERY AND DISCHARGE

Methergine 0.2 mg. I.M. _____

Methergine 0.2 mg. P.O. _____

Doxycycline 200 mg. P.O. _____

Acetominophen 1000 mg. P.O. _____

Ibuprofen 400 mg. _____

Other _____

Return for Pregnancy test 2 weeks Yes No

Ectopic Precautions Yes No

Signed _____M.D.

Time In _____ Time Out_____

Procedure Counselor: _____

RECOVERY ROOM

Hour		
Blood Pressure		
Pulse		
Bleeding	N Sm Mod Hvy	N Sm Mod Hvy
Pain/Cramps	N M M S	N M M S

Allergies: No Yes _____

Previous Medication Dosage Route & Site Time By

1.

Medication Administered	Dosage	Route & Site	Time	By
1.Doxycycline	200mg.	P.O.		
2.Ibuprofen	400mg.			
3.				
4.				
5.				

Medication Dispensed Dosage Amount By

1. _____
2. _____
_____

Excuse needed for_____ Yes No
No. of days___Given Yes No

Transportation:
Car Cab Bus Train Plane Walk
Other____
By Self With Family/Friend

Emotional Condition:
Interacts openly Composed Withdrawn Upset
Referred for Personal Counseling

Physical Condition:
No problems Cramps: Mild Moderate Severe
Other_____

_____ M.D.
Time of Discharge _____AM/PM
Signed _____RN/LPN
Signed _____RN/LPN

WOMEN'S HEALTH SERVICES, INC.
CONTRACEPTIVE CLINIC

Patient Name _____ Patient Number___

Put an (X) in the appropriate column for each of the following you have had *only since your last visit to the Women's Health Services, Inc.*

* * *

Patient Name _____ Patient Number___

Visit # Date Visit # Date

Chief Complaint:	Chief Complaint:
History:	History:
Temp. BP P Wt. LMP	Temp. BP P Wt. LMP
Thyroid:	Thyroid:
Breasts:	Breasts
Heart:	Heart:
Lungs	Lungs
Abdomen:	Abdomen:

Pelvic: Vulva	Pelvic: Vulva
Vagina	Vagina
Cervix	Cervix
Corpus	Corpus
Adnexa	Adnexa
Rectal	Rectal
Extremeties:	Extremeties:
Tests: PAP GC	Tests: PAP GC
Wet Prep	Wet Prep
Other	Other
Impression:	Impression:
Plan:	Plan:
Contraception:	Contraception:
Next Appointment: Wks. Mos.	Next Appointment: Wks. Mos.
RN/PA M.D.	RN/PA M.D.

* * *

CONSENT FOR ABORTION

I hereby authorize a Staff Physician to perform upon me a VACUUM ASPIRATION ABORTION, including all the medical aspects, which have been explained to me.

I consent to the administration of anesthesia to be applied by or under the direction of the staff physician, and to the use of such anesthetics as s/he may deem advisable.

In the course of the abortion if any unforseen condition arises which, in accord with good medical practice, calls for procedures in addition to or different from those contemplated, I further request and authorize the staff physician to perform such procedures, and to administer any medication which s/he may deem advisable and to have me admitted to a hospital facility.

I understand it is my responsibility to bring to the attention of Women's Health Services, Inc. any unusual symptoms following the abortion and to report for check-ups and pregnancy tests as recommended.

I understand the nature and purpose of an abortion by vacuum aspiration. I understand that there are other abortion techniques. I understand the alternatives to abortion, including childbirth and adoption. I understand the risks involved with an abortion, and the possibility of complications and detrimental physical and psychological effects which may occur. These include, by way of illustration and not limitation, hemorrhage, infection, perforation, hematometra, cervical damage, incompleteness as well as the possible need for further surgery (e.g. laparoscopy, laparotomy, hysterectomy, removal of tubes and ovaries), possible sterility and fatality. All of these matters have been fully explained to me.

I authorize Women's Health Services to dispose of all fetal tissue in accordance with state and federal laws.

I CERTIFY THAT THIS ENTIRE ABORTION CONSENT HAS BEEN READ TO ME AND THAT I HAVE READ OR HAD THE OPPORTUNITY TO READ THE ENTIRE CONSENT FORM AND THAT I UNDERSTAND THE ABOVE CONSENT FOR ABORTION AND THE THE EXPLANATIONS HEREIN REFERRED TO WERE MADE.

Date_____ Time_____

Signature of Patient _____

Signature of Person authorized to give consent, if not patient _____

Relationship to Patient _____

Signature of Physician _____

Signature of Witness _____

ECTOPIC PRECAUTIONS

I certify that I have received a copy of the sheet listing the precautions for possible extopic pregnancy, have read it and understand the importance of the medical follow-up. Date_____

Signature of Patient _____

Alternate contact person in addition to myself:

_____

Relationship _____

Phone Number _____

Signature of Witness _____

EARLY ABORTION SPECIAL INSTRUCTIONS

I certify that I ahve received a copy of the sheet describing the special instructions for early abortion patients, have read it and understnad the importance of the medical follow-up. Date _____

Signature of Patient _____

Alternate contact person in addition to myself:

_____

Relationship _____

Signature of Witness _____

POST ABORTION INSTRUCTIONS

I certify that I have received a copy of the sheet describing instructions for after the abortion, have read it and understand the importance of the medical follow-up

Date_____

Signature of Patient _____

Signature of Person authorized to give consent, if not patient:

_____

Relationship _____

Phone Number _____

Signature of Witness _____

CONSENT FOR ORAL CONTRACEPTION

I have received and agreed to read the patient information enclosure regarding oral contraceptives distributed by the manufacturer. I understand that it is my responsibility to bring to the attention of Women's Health Services, Inc. any unusual symptoms and to report for check-ups as recommended. I CERTIFY THAT I HAVE READ (OR HAD READ TO ME) AND FULLY UNDERSTAND THE ABOVE CONSENT TO CONTRACEPTIVE SERVICES AND SUPPLIES, AND THAT THE EXPLANATIONS HEREIN REFERRED TO WERE MADE. Date_____

Signature of Patient _____

Signature of Person authorized to give consent, if not patient:

_____

Relationship to patient _____

Phone Number _____

Signature of Witness _____

I do hereby consent to have Women's Health Services, Inc. provide to me the service noted below.

Date_____Gynecological Exam
Signature of Patient_____
Date_____Antibiotic Therapy
Signature of Patient_____
Date_____Lamicel Insertion
Signature of Patient_____

FINANCIAL PAGE

Insurance Company _____
Insurance Address_____
Agreement # _____
Group # _____
Subscriber_____
Sub. Employer _____
HMO Center _____
HMO MR# _____
HA Family I.D.# _____
MA # _____
Line # _____R.C._____
State _____
Exp. Date_____ D.D._____
_____ D.D._____
_____ D.D._____
_____ D.D._____
_____ D.D._____
MC/Visa# _____
Sub. Name _____
Exp. Date _____
_____

Defendants' Exhibit 8:
WHS Advertisements

The Pittsburgh Press

Ask a friend

"I was very pleased with the professionalism and personal treatment. I would refer any of my friends to WHS."

About Women's Health Services
"Counseling Services for Men & Women"
"PMS Program--Abortion Services--Gyn Care"
Fulton Building ■ 107 6th St.
Downtown Pittsburgh
(412) 562-1900

* * *

WAMO 1500 Chamber of Commerce Bldg.
FM 106 Pittsburgh, Pennsylvania 15219-1905
(412) 471-2181

WOMENS HEALTH SERVICES .....

IF YOU'RE CONCERNED ABOUT AN UNPLANNED PREGANCY...HELP IS JUST A PHONE CALL AWAY....562-1900. WOMENS HEALTH SERVICES....FULTON BLDG...DOWNTOWN OFFERS YOU HELP IN MAKING DECISIONS ABOUT YOUR LIFE. WOMENS HEALTH SERVICES HAS A HIGHLY

SKILLED GYNECOLOGICAL STAFF AND A COUNSELING STAFF AND YOUR VISIT WILL BE KEPT COMPLETLY CONFIDENTIAL. IF THE PIECES OF THE PUZZLE DON'T QUITE FIT...LET WOMENS HEALTH SERVICES HELP....OUR PHYSICIANS PROVIDE SKILLED MEDICAL CARE AND YOU'LL BE TREATED IN A REASSURED AND COURTEOUS MANNOR. FOR A GYN APPOINTMENT..OR ANSWERS TO QUESTIONS ABOUT AN UNPLANNED PREGNANCY CALL THE PHONE STAFF AT 562-1900....BETWEEN 8 and 5PM ...MONDAY THRU FRIDAY....SATURDAY 8 to 4PM.....WOMENS HEALTH SERVICES...IN THE FULTON BUILDING ...DOWNTOWN.....FREE PREGNANCY TESTING IS AVAILABLE DAILY. FOR MORE INFORMATION CALL WOMENS HEALTH SERVICES AT 562-1900.....HELP IS JUST A PHONE CALL AWAY.

* * *

THE CAMPUS
OF ALLEGHENY COLLEGE

Ask a friend

"Everyone treated me nicely. I felt comfortable and relaxed. the procedure was explained step by step. I liked that."

About Women's Health Services

Where Experience Makes A Difference
Early & Later Abortions--Confidential Counseling
Fulton Building ■ 107 6th St.
Downtown Pittsburgh

1-800-323-4636

* * *

Phone Listing:

ABORTION SERVICES DIVISION OF WOMEN'S HEALTH SERVICES INC

1st & 2nd Trimester Abortions in a comfortable setting. Highest medical standards.

107 6 St Pittsburgh PA
Toll Free Dial "1" & Then--800 426-4636

Defendants' Exhibit 9:
Excerpts from Planned Parenthood of Southeastern Pennsylvania (PPSP) Center Policy and Procedure Manual

• • •

C. Counseling and education.

1. All pregnancy test clients will receive appropriate options counseling if desired by patient. Intensive counseling may be scheduled for a separate visit if deemed necessary by client and counselor.

2. The purpose of pregnancy counseling and referral is to support a woman in clarifying and achieving her immediate reproductive goal. All applicable alternatives (parenting, adoption, foster care, infertility testing, pregnancy termination, contraception) will be presented in an unbiased manner. As a result of the counseling session, the patient should understand:

a. Her alternatives, including description and approximate cost of services, and time constraints.
b. Advantages and disadvantages of her alternatives.
c. Specific resources for reaching her goal, including the support of her partner, friends and/or family, medical care, financial aid, transportation, bilingual services, counseling and education.
d. Methods of contraception available if found to be not pregnant.
e. What to do in an emergency.
f. Information about the accuracy of the test.

3. All counseling is confidential (within legal limitations) and will be conducted in privacy.

a. Results should be given to the woman alone and the partner or significant other brought in if desired by her.

4. Every patient age 17 and younger who is making a decision concerning a positive pregnancy test shall be encouraged to talk to a parent or an alternative adult.

5. Every patient should be given the opportunity to consider:

a. Clinical information with regard to her gestation of pregnancy.
b. Any aspect of her medical evaluation which pertains to the options available to her.
c. Review of contraceptive history and plans.
d. Options available for continuing or terminating a pregnancy, including appropriate referrals.
e. Potential effect each option suggests for the future.

6. A Consumer Feedback Form (#54) must be given to each patient referred for abortion services.

a. Request the patient return the Consumer Feedback Form within six weeks.

7. Document that pregnancy alternatives were discussed.

8. Pregnancy options counseling may be offered without testing if woman brings written results of a positive pregnancy test done elsewhere. Women who have used home pregnancy tests should have

another test done at the Center.

D. Referrals.

1. Prenatal care and delivery.
   a. A minimum of two direct service referrals must be provided.
   b. The CHOICE Hotline can be given as an additional resource.

2. Adoption and foster care.
   a. Provide the patient with appropriate referrals.

3. Abortion.
   a. A minimum of three referral sources is given from the approved Referral Lists (#55a and 55b) as indicated and available.

4. Up to date information is maintained at each site regardinq social services, Medicaid, drug abuse programs, as well as all medical referrals.

5. Document all counseling, advice, and referrals on the medical record.

6. Consumer Feedback form (#54) is given to patient to be completed and mailed back to PPSP center.

E. Counseling personnel.

1. Personnel suitable for pregnancy options counseling
   a. Physicians, clinicians, Center Managers, Center Assistants, social workers, and selected, trained and appropriately supervised volunteers.

2. Qualifications of counseling personnel.
   a. The ability to respect, understand and empathize with the woman as an individual.
   b. A sincere belief in the right of the woman to make her own decision after she has explored all the options.

3. Training of counseling personnel.
   a. The counselor must have a complete knowledge of the facts regarding abortion. These include:
      1) The facts about relative risks of early abortion as opposed to late abortion;
      2) Availability of services;
      3) Facility evaluation;
      4) Cost of services.
   b. Counselors must be thoroughly knowledgeable about all methods of contraception and community-wide contraceptive services.
   c. Counselors must have knowledge regarding facilities for prenatal care.
   d. Counselors must have knowledge regarding the necessary procedures for adoption and the location of adoption agencies.
   e. Counselors must have knowledge regarding the availability of insurance coverage or other reimbursement for abortion, and prenatal care and delivery.
   f. Counselors must have knowledge of the availability of psychiatric consultation which may be requested or which may be medically advisable.
   g. Counselors must be familiar with ail legal requirements for sterilization procedures which may be requested in conjunction with abortion.

• • •

K. Procedure for Center Assistant/Counselor.

1. Each patient will be seen individually by a Center Assistant/Counselor. Counselors will pick up charts, so keep completed charts in order. Keep Center Manager informed of unusual situations that may need special attention or patients with potential problems.

2. Have on hand:
   a. Pap slips.
   b. GC slips.
   c. Serology slips.
   d. Medical and information forms.
   e. Several pens.
   f. Pencil.
   g. China marker.

3. Greet patient and take her to counseling office. Explain your role as it relates to patient visit and Center procedure. The counselor performs role of advocate, assistant, and support to the patient.

4. Review patient's medical history (#16) with her. Make special note of potential problems and consult with appropriate staff as needed. Be sure all forms are completed.

5. Discuss patient's decision to have an abortion and provide opportunity for her to explore feelings. Let her know other options are available and you can provide her with referrals. Involve others accompanying client to facility, if appropriate. Support person can be included in procedure room

if, in staff's judgement, their involvement would be supportive to the client.

6. Explain, answer questions, discuss the abortion fact sheet (#21), including risks, and consent (#18). Have client sign and witness. Must be able to give informed consent.

7. Review birth control methods (#42) and discuss patient's choice. Have patient sign contraceptive consent and witness.

8. Review "safer sex" practices.(#99)

9. Review possible medical concerns with Center Manager, medical support staff, and physician prior to the procedure.

10. Ascertain that slips for GC and Pap have been completed and are in the patient's chart. Label Pap slides, GC plates with client name, date, and specimen number if appropriate. Be sure all specimen numbers have been recorded on lab sheet in chart.

11. Record results of pregnancy test, urine dipstick, hematocrit, and Rh factor on lab sheet in chart.

12. Record drug allergies and significant medical problems in red on outside of chart.

13. Provide a written social history in patient's record reflecting the counseling session. The followinq questions can be used in evaluating the abortion counseling session:

   a. Do I feel I have a clear picture of the

woman's intellectual and emotional status in regard to her abortion decision?
b. Are there conflicts between her emotional and intellectual status on the abortion decision?
c. Who else is involved in decision-making and what are their reactions? Does this woman have support for her decision?
d. If the woman decided alone, how did she reach the decision to do so and what are her feelings about it?
e. What are her contraceptive plans for the future?
f. Were there other problems, i.e. relationship, sexuality that were dealt with?
g. How will she react post-abortion? Does she desire future counseling services?
h. Is she clear in regard to the abortion procedure?
i. For extended first trimester procedures, follow all of the above steps plus:

1) Explain laminaria insert procedure plus possible complications.
2) Have patient sign laminaria consent (#90) and witness.
3) Schedule abortion appointment for the following day and review pre-abortion instructions.

* * *

Defendants' Exhibit 10:
Excerpts from PPSP
Request for Abortion Form

Planned Parenthood Southeastern Pennsylvania

Request for Abortion

Name _____

Address _____ Birth Date _____

I have received from Planned Parenthood a fact sheet containing detailed information on the nature and purpose of an abortion, the risks involved, and the possibility of complications. I have read the fact sheet which has been explained to me, and which I understand. I have had all my questions answered. I also understand that a doctor is available to answer any additional questions I may have. No guarantee or assurance has been made to me as to the results which may be obtained and I am aware, on the basis of the fact sheet and the explanation I received, of the risks involved in an abortion and the possible complications.

I hereby request that a doctor authorized by Planned Parenthood perform an abortion upon me if s/he, in her/his medical judgment approves the performance of the abortion. If any unforeseen condition arises in the course of the abortion calling in her/his judgment for procedures in addition to or different from those contemplated, I further request and authorize her/him to do whatever s/he deems advisable to protect my health and welfare.

I consent to the administration of a local anesthetic. To my knowledge, I am not allergic to any anesthetics.

I hereby give my permission to the employees of Planned Parenthood Southeastern Pennsylvania and others authorized by them to use information contained in my medical record for statistical purposes, with the understanding that confidentiality will be maintained.

Signature _____ Date_____

I witness the fact that the patient received, read, and said she understood the fact sheet.

Witness _____

[ ] **Physicians must sign only for minors under the age of 18 without parental consent:**

I have discussed with the patient the abortion she has requested and I believe she is sufficiently mature and intelligent to understand the nature and consequences of her condition and of the procedure. I believe that the abortion she has requested is in her best interest.

Physician _____

Defendants' Exhibit 11:
Excerpts from PPSP Fact Sheet

Facts About Early Abortion

What It Is

A surgical procedure to end a pregnancy within 14 weeks from the first day of the last menstrual period.

How It Is Done

The standard method is vacuum aspiration (suction curettage):

1. A local anesthetic is injected into or around the cervix (the lower part of the uterus). You may notice stinging or pressure, which goes away quickly. Some women don't feel anything.

2. The opening of the cervix is stretched slowly by a series of narrow rods (dilators), each a little wider than the one before. The largest dialator may be about as thick as a fountain pen. You may feel strong cramping during this part of the procedure.

3. When the cervical opening is wide enough to admit it, a cannula (a hollow plastic tube) is inserted into the uterus. This tube is attached to a suction machine, which is then turned on. You may notice a pulling or tugging feeling at this time.

4. After the uterus has been emptied by gentle suction, an ordinary spoon-shaped curette may be used to make sure that the uterus has been

emptied.

Possible Problems

As with any kind of surgery, complications can occur with early abortion. Early abortion by vacuum aspiration is, however, very safe. Fewer than 1 woman in 100 will have a serious problem, including but not limited to:

Infection

Infection is caused by germs from the vagina and cervix getting into the uterus. The risk of infection related to early abortion is less than 1 in 100 cases. Such infections mostly respond to antibiotics, but, in some cases, a repeat vacuum aspiration or hospitalization is necessary. Surgery may also be required. You can decrease your chances of developing an infection by *not* having intercourse until after your post-abortion exam and *not* inserting ANYTHING into your vagina, including tampons.

Bleeding

Bleeding from the uterus heavy enough to require treatment occurs less than 1 in 1,000 cases. This bleeding problem may require medications to help the uterus contract, a repeat vacuum aspiration or dilation and curettage, or rarely, surgery.

Cervical Tear

The cervix sometimes is torn during the procedure. This happens in less than 1 in 100 cases. Stitches may be required to repair the injury.

Incomplete Abortion

Sometimes, the contents of the uterus may not be quite emptied. The frequency of this event is less than 1 in 100 cases. This problem can lead to

infection, hemorrhage, or both. To remove the tissue, it may be required to repeat the vacuum aspiration or perform a dilation and curettage at the clinic or in a hospital. In rare instances, surgery may be required.

Perforation

Rarely, an instrument may go through the wall of the uterus. This event happens in about 2 per 1,000 cases. Should this happen, hospitalization is often required for observation and/or completion of the abortion. To inspect the condition of the uterus in this state, a small telescope (laparoscope) is inserted through the navel. Sometimes, an abdominal operation is required to repair the damage. This can include hysterectomy (removal of the uterus), which makes it impossible to have children. The frequency of hysterectomy in this setting is about 1 in 10,000 cases.

Failure to Terminate the Pregnancy

Once in a while, the early abortion procedure will not end the pregnancy. The chance of this event is about 2 per 1,000 cases. This possibility is one reason that a post-abortion examination is essential. In such cases, another abortion procedure is suggested, since the first attempted abortion can harm normal development of the pregnancy. The other possibility is that a tubal (ectopic) pregnancy may exist, which requires an abdominal operation to remove.

Death

Early abortion is one of the safest operations in all of medicine. Information from the Centers for Disease Control (CDC) shows that the risk of death

from an early abortion is about 1 per 100,000 cases. In contrast, the risk of death related to tonsillectomy is about 3 deaths per 100,000 cases. The risk of a woman dying from full-term pregnancy and childbirth is at least 7 times greater than that from early abortion.

Anesthesia Reaction

Some women may be allergic to novocaine derivatives. If you know this, it is important to tell the doctor.

Effect of Abortion on Future Wanted Pregnancies

At this point there is no clear proof that one early abortion carries any risk to future pregnancies. Some studies have shown that women who have had two or more such abortions may have an increased risk of premature births or miscarriages in future pregnancies. Different studies have shown otherwise.

Emotional Reactions

Strong feelings after abortion are common, and when they happen they mostly go away quickly. Most women report a sense of relief, although some feel depression or guilt. Serious psychiatric disturbances (such as psychosis or serious depression) after abortion appear to be less frequent than after childbirth.

Deciding whether or not to have an abortion is a very private matter. You need to be sure and comfortable that having an abortion is what you want to do, even if it is a hard decision to make.

Defendants' Exhibit 13:
Excerpts from Guidelines of
Women's Suburban Clinic (WSC)

Guidelines of Women's Suburban Clinic (WSC)
Protocol

OPTIONS COUNSELING/REFERRAL

I. *ELIGIBILITY:* Any woman who has

- -- a positive pregnancy test
- -- requests options counseling at WSC
- -- is eligible for options counseling.

II. *INTAKE:*

-- An appointment card is used for information on options counseling clients (see forms).

-- This card is completed as described in abortion intake procedures except that the medical history is not necessarily taken (if medical history is not taken this is noted in pencil on front of card).

-- Appointments are scheduled during the counselor's assigned times, as designated in the appointment book.

-- Options counseling clients are NOT given a "Disclosure of Risks, Benefits, and Alternatives to Abortions" to read after they return their medical history to the front desk.

• • •

V. *DISPOSITION:*

-- If a client chooses to have an abortion, she can be scheduled for an appointment at WSC or referred to another appropriate facility (see Referral Counseling). If a woman chooses to have an abortion at WSC, the appointment should not be made for the same day as the option counseling.

-- If a woman chooses to continue the pregnancy, the counselor may make a referral to appropriate community resourses (Examples: Pre-natal Care or Adoption Informatian).

-- Options Counseling Notes will be recorded by the counselor (see forms-Appendix B).

• • •

ABORTION AND SUPPORT SERVICES

VII. *COUNSELING*

The individual counseling is provided to all women who come to WSC for abortion services (see Counseling Standards). This counseling, usually done on the same day as the abortion, is <u>not</u> offered for the purpose of exploring pregnancy (see Options Counseling), although alternatives may be discussed. Rather, this counseling session assumes that the decision to abort has been carefully thought out prior to the session. The objectives of this session

are clearly defined under "Objectives" in the Counseling Standards section of the WSC Guidelines.

If, in the process of the session, the counselor determines that the client has not clearly decided to abort, he/she will suggest that the client not proceed with the abortion that day. The counseling session then procedes under the protocol for "Options Counseling, with the abortion (if chosen) being rescheduled for another day.

• • •

c. *The Counseling Session:* The pre-abortion session flows according to the clients needs and questions. The client's partner or other accompanying person is also encouraged to accept information, ask questions, and explore feelings at WSC. These "signifigant others" may be invited to joinq the counseling session, but only after the women has seen the counselor alone, thus giving her the opportunity to discuss any private concerns. (see also, Counseling Signifigant Others).

• • •

E. *Limitations and Referrals:* The counselors role is to discuss the clients' concerns primarily regarding the abortion decision. For those women who display a need for further counseling or assistance which is non-abortion related, the counselor may refer the client to an appropriate agency or individual. A resource book is maintained by WSC under the supervision of the head counselor. The Resource Book includes numerous community resources.

F. *Counseling Signifigant Others:* Any person who accompanies a client to WSC is offered the opportunity and is encouraged to see a counselor. This may include the client's partner, her parents, and/or any "Signifigant Other". The counselor may see the Signifigant Other with the client, or after the clients' counseling session. This is left up to the discretion of the client and the counselor.

• • •

Defendants' Exhibit 14:
WSC Disclosure of Risk, Benefits and Alternatives Form

WOMEN'S SUBURBAN CLINIC

DISCLOSURE OF RISKS, BENEFITS AND ALTERNATIVES

Because abortion is a form of minor surgery, which, like all surgery, has certain statistical risks, it is the policy of Women's Suburban Clinic to provide detailed information regarding the risks, benefits and alternatives to abortion so that you can make a clear and conscious choice.

Alternatives: The alternative to ending a pregnancy is to continue it to term and birth. This usually leads to parenthood or adoption. Pregnancy and childbirth have some medical and psychological risks. Both the benefits and risks of parenthood and adoption should be carefully considered before deciding upon an abortion.

Benefits: The benefits of early abortion depend upon the individual. Abortion permits the planning of parenthood. Abortion eliminates the decision between parenthood and adoption.

Risks: 96% of all early abortions take place without any complications at all. Complications associated with abortion are generally less frequent than with childbirth. In childbirth some 15 to 20 out of 100,000 women do not survive. Abortion is 5 to 10 times safer.

Below is a list of possible complications to abortion. You will be asked to sign a consent form indicating that you understand these risks before you have an abortion.

Please read this form carefully so that you understand that we cannot guarantee that the results obtained from an abortion will always be perfect. Complications may occur and require further treatment. A member of Women's Suburban Clinic staff is on-call 24 hours a day for consultation; and we will assume financial responsibility for treatment of all medical (not psychological) complications to abortion if such treatment is given at or recommended by Women's Suburban Clinic.

Medical Risks:

a) Risk of Infection: In approximately 1 in 100 cases, minor or possible major infections can occur after an abortion. Antibiotics are necessary to treat these infections and, very rarely, infections may lead to reduced fertility.

b) Incomplete Abortion: Sometimes all of the tissue may not be removed during the abortion. This happens in approximately 1 in 100 cases, and may lead to infection unless treatment is begun soon or the abortion is redone.

c) Continued Pregnancy: In as many as 1 in 100 cases, a woman may still be pregnant after an abortion. This may be due to multiple pregnancies (i.e. twins), a double uterus, or a pregnancy in the tubes (ectopic pregnancy). A failed abortion may be detected by follow-up exam and pregnancy test after which the abortion can be redone. A tubal or ectopic pregnancy is difficult to detect and will require a hospitalization and surgery.

d) Bleeding or Hemorrhage: Heavy bleeding immediately or shortly after an abortion may happen in a very small number of cases. This requires evaluation and treatment, which depends upon the cause of the bleeding.

e) Perforation or Laceration: Very rarely an instrument may tear the cervix or puncture the wall of the uterus. These cuts will generally heal themselves, with no treatment, but occasionally they may require hospitalization or surgery.

f) Anesthetic Reaction: Anesthetics do not always eliminate all pain. In very rare instances, local anesthetics cause extremely severe reactions, including convulsions or cardiac arrest.

Psychological Risks:

Sometimes women express negative feelings after having had an abortion. These feelings may include a sense of loss, guilt, regret or sadness.

The likelihood of your experiencing these feelings depends on many factors including your feelings about abortion, your religious convictions, your cultural and social norms, and the support you receive from your family and friends.

You will have the opportunity to discuss these factors with a counselor before the abortion to reduce the likelihood of their causing negative feelings later. If negative feelings do occur, you may return to Women's Suburban Clinic for counseling and/or referral for more involved therapy.

Defendants' Exhibit 17:
WSC Information Prior to Consent/
Certification by Patient Form

INFORMATION PRIOR TO CONSENT

I, _____, certify that on _____, 1988, I orally informed _____ prior to her consenting to an abortion, of the nature of the proposed procedure and treatment of abortion and of the risks and alternatives to abortion or treatment that a reasonable patient would consider material to the decision whether or not to undergo the abortion.

_____ physician

_____ qualified physician assistant

_____ health care practitioner

_____ technician delegated by either physician

CERTIFICATION BY PATIENT

I, _____, certify that prior to my consenting to an abortion at the Women's Suburban Clinic, the person who has signed the above statement called INFORMATION PRIOR TO CONSENT ' told me about the nature of the proposed procedure and treatment of abortion and of the risks and alternatives to abortion and treatment.

Date: _____, 1988

_____
patient

Defendants' Exhibit 18:
WSC Parental Involvement Form

Parental Involvement

I, _____, have carefully considered with the counselor the possibility of involving my parents or guardians in my decision to terminate my pregnancy. However, I choose not to do so. I understand that if, during my abortion, I have any complications which hospitalization, the hospital may choose to call my parents. On the medical history form, I have given Women's Suburban Clinic the number where my parent can be reached in case of emergency.

_____
Client's Signature

or

I am the parent/guardian of _____ and I am aware of her decision to abort.

_____
Signature

or

My parent/guardian is aware of my decision to abort, but could not be present today. I have given Women's Suburban Clinic a number where my parent can be reached in case of emergency.

_____
Client's Signature

Defendants' Exhibit 19:
WSC Physician's Certification Form

PHYSICIAN'S CERTIFICATION

I certify that prior to the abortion I had a private medical consultation with the above client and determined that in my best clinical judgment the abortion was necessary.

Signature of Physician

Defendants' Exhibit 20:
WSC Protocol Regarding Minors

II. STANDARDS

D. Protocol Regarding Minors

1. It is one of the underlying philosophies of Women's Suburban Clinic that all women *capable of informed consent* be provided the opportunity to "choose". These choices involve the decision regarding an unplanned pregnancy, the decision regarding whom they choose to inform about their pregnancy and what method of birth control they choose to use. As with any woman, this philosophy also pertains to minors. However, in the case of a minor (any woman under 18 years of age), the issue of whom she chooses to inform or not inform is carefully explored.
2. For any minor who at the time of scheduling her abortion has not informed one of her parents of her decision, the following will occur:
   a. Anyone under 18 years of age whose parent(s) do not know about her decision to have an abortion is *strongly encouraged* to come to Women's Suburban Clinic for precounseling. The reason for this is to allow the counselor on opportunity to explore more fully with the young woman her feelings regarding involving her parent(s). Further, a pre-counseling session would allow the teenager time to discuss her pregnancy with her parent(s) in the event that after counseling she chooses to do so. If the young woman chooses not to involve her parent(s) the counselor would then want to

explore other people (siblings, other relatives, or friends) who could provide a support system. It is ultimately the right of this teenager to decide whom, if anyone, she wants to involve. In all cases the minor will be asked on her Medical History form the name of her parent or guardian, and how to contact them in the event of an emergency.

3. For those minors who choose not to inform their parent(s) it is the role of the Women's Suburban Clinic staff, as with all clients, to review and educate them regarding how to take a temperature and read a thermometer, what is considered a complication, and what to do in the event that a complication occurs.
4. All minors will be asked to complete a parental involvement form at the completion of counseling.

Defendants' Exhibit 26:
Excerpts from Reproductive Health and Counseling Center (RHCC) Consent Forms

* * *

INFORMATION PRIOR TO CONSENT

I, _____, certify that on _____, 19__, I orally informed _____ prior to consenting to an abortion, of the nature of the proposed procedure and treatment of abortion and of the risks and alternatives to abortion or treatment that a reasonable patient would consider material to the decision whether or not to undergo the abortion.

_____ PHYSICIAN	_____ QUALIFIED PHYSICIAN ASSISTANT
_____ HEALTH CARE PRACTITIONER	_____ TECHNICIAN DELEGATED BY EITHER PHYSICIAN (COUNSELOR)

CERTIFICATION BY PATIENT

I, _____, certify that prior to my consenting to an abortion at the Reproductive Health and Counseling Center, the person who has signed the above statement called "Information Prior To Consent" told me about the nature of the proposed procedure and treatment of abortion and of the risks and alternatives to abortion and treatment.

_____, 19_____
DATE PATIENT

• • •

PHYSICIAN'S CERTIFICATION

I, _____, hereby
Patient's Signature

acknowledge that I will have a private medical consultation with Dr. _____. I have just cause to terminate this pregnancy because of the following reason:

___ Physical

___ Emotional

___ Psychological

___ Familial

___ Age

I, _____,

M.D. through a private medical consultation, do hereby certify that to the best of my clinical judgment this abortion is necessary.

• • •

After careful consideration I have decided:

1) I will not inform my parents of my decision to terminate my pregnancy.

(2) Parent(s) are aware of my decision, but are unable to be here today.

I understand that while I am a patient of the Reproductive Health and Counseling Center that all reasonable measures will be taken to maintain my confidentiality. However, if it is necessary for me to be hospitalized at any time during or after my care here, the hospital may choose to notify my parents about any treatment they may give me.

_____
Name

_____
Date

_____
Witness

Defendants' Exhibit 30:
RHCC Advertisements

REPRODUCTIVE HEALTH AND COUNSELING CENTER

- first and second trimester abortion services
- general & local anesthesia
- Routine gynecology care
- pregnancy testing
- counseling services
- vd screening
- vasectomy service

Quality reproductive health care . . .

ALL SERVICES HELD IN STRICT CONFIDENCE!

Call 874-4361

(Crozer Chester Medical Center Annex)
15th & Upland Av Chester, Pa.

Defendants' Exhibit 32:
Allentown Women's Center (AWC)
Counseling Checklist

COUNSELING CHECKLIST

1) Determine that patient has a clear decision to terminate pregnancy, knows options, and determine a log reasons for abortion (ie: financial, emotional, age, timing factor, life circumstances, medical, doesn't want children or any more children).

2) If first pelvic exam, prepare patient.

3) Explain procedure, discuss pain management, assuage fear, empower patient.

4) Obtain informed consent, explain risks.

5) Review medical history and flag problems, discuss if abnormal menstrual period.

6) Explore birth control - pursue and explain only if patient desires the information

7) Have patient sign appropriate consents. Must sign abortion consent, dispensing of medication consent, and medical records release. Oral contraceptive consent must be signed only for those patients wanting to start the pill immediately.

ADDITIONAL INFORMATION REQUIRED FOR GENERAL ANESTHESIA

1) Provide complete aftercare instructions.
2) Explain how to take oral contraceptives for those patients taking then for the first time.
3) Have patient sign general aneathesia consent.
4) Obtain patient's driver's signature.

MINORS

1) Explain that if complications develop, their confidentiality may be broken.
2) Make certain minor knows all options.
3) Determine and record whether patient's parent(s) are here or know she's here. Record reason(s) why a patient chose not to tell her parents.
4) If a parent is here, the parent MUST co sign for abortion.

IMPORTANT FACTORS TO CONSIDER WHEN DOING PRE-ABORTION COUNSELING

1) Make no promises that there will be no problems now or later.
2) It is better to see patient alone, at least briefly.
3) Counseling should be organic and cover concerns patient presents. Be empathetic, nonjudgemental, and caring.
4) Body language of counselor is just as important as what she says.
5) Observe patient to make sure she's listening. Do not over inform. Her ability to process may be restricted.
6) Be nonjudgemental in recording counseling notes. (Do NOT record anything that you wouldn't want patient to read, or anything that could be used against her later, ie: court).
7) Repeat patients who have had more than one

abortion. Review risks, and concentrate efforts on encouraging effective birth control use.
8) Prepare patient for being ineligible for procedure if you suspect she could be greater that 14 weeks LMP.
9) If patient is greater than 12 weeks LMP, advise her that she may need an ultrasound.
10) If you feel uncomfortable (for any reason) counseling a particular patient, give that patient to another counselor.
11) Ambivalent patient: When you have exhausted all possible information giving and patient is still ambivalent you can give patient these options.

a) Offer patient to leave the clinic and rethink decision. Give her time that she must be back if she still wants abortion that day.

b) Have patient and significant other sit together in counseling room to discuss decision. Counsel another patient and go back to her later.

c) If you feel patient needs more time to decide, you have the right to tell her that we can reschedule her appointment for another day, that she needs more time to make her decision.

12) Time management is important with short term counseling. If you are having a problem with a counseling session, notify clinic supervisor so that patient flow won't be disturbed.
13) Take time to share, vent, and discuss counseling cases with other counselors here.
14) If you are having any problems with a client in counseling don't hesitate to have another counselor or clinic supervisor assist you with that particular client.

Defendants' Exhibit 33:
Excerpts from AWC
Confidential Patient Record Form

• • •

For patients under 18:
Who of the following knows of and consents to your abortion?
Mother_____ Father_____
Guardian _____
If they are not aware you are here, why not?
_____

• • •

PROCEDURE

Name_____ Date_____
Patient discussed need for aboriton with physician and stated it is necessary _____
Physician's Initials
BP_____ P_____ Temp._____
LMP Date_____or_____weeks LMP
Heart_____ Lungs_____ Abdomen_____
Comments _____
Pelvic Exam: Normal _____
Abnormal findings: _____
Uterus: Anterverted _____
Retroverted _____
Midposition _____
Estimated duration of gestation based on uterine size:
_____
Pap smear _____
GC culture, cervix___ rectum___ urethra___

pharynx____
Room_____ Nurse:_____
Pre-op medication: _____

OPERATIVE REPORT
Procedure Performed

Patient was placed in dorsal lithotomy position, prepped and draped in usual manner. A paracervical block was administered using ____cc of ____% _____caine. The uterus was sounded to ____cm. The cervix was dialated to a #____ dialation using gradually increasong dialators. A #____ cannula was placed in the uterus and vacuum aspiration was performed. Uterine exploration with a sharp curette followed. Estimated blood loss was ____cc. Gross examination of POC Grams_____
Normal POC_____ Other (describe)_____
Villi seen_____ Consistent with ____ weeks gestation

_____

Send specimen for microscopic pathology_____
Instructions_____

_____.

Complications:_____
_____
_____
_____
_____

Post-Operative Medication

___Immune globulin, mini-dose	___Ergotrate	___Other
___Immune globulin, full-dose	___Birth Control Pills	_____
___Pitocin	___Tetracycline	_____

Notes or comments_____
Procedure Not Performed

_____

_____

_____

Physician's Signature _____
Referral:_____

_____

Counselor Signature _____

* * *

Do not sign unless you fully understand the following.

I, _____being_____years old, request that my present pregnancy be terminated. I understand that the termination of this pregnancy (i.e. abortion) will be by vacuum aspiration and curettage as explained to me. I understand that Dr._____ or a designated associated physician will be performing the termination procedure.

I further understand and give my consent to the taking of medical tests, cultures, and smears that are deemed necessary.

I have fully and completely disclosed my medical history, including allergies, blood conditions, prior and current use of or reactions to medications and drugs. I understand that a full and complete disclosure of my medical history is important to help minimize the risks of complications which may occur with termination of pregnancy. I understand that the physician of Allentown Women's Center is relying on my disclosures as being truthful and complete.

The first day of my last normal menstrual period was____19__. I understnad that this information concerning my last period is important to the diagnosis and method of treatment, and that the physician's decision to proceed with the termination is based on the above information as well as findings from examination.

I fully understand the purpose of the procedure is to terminate my pregnancy. I know that I can continue the pregnancy, but it is my choice to end it now. No one has forced me to do so.

I consent to the administration of such local anesthesia as may be deemed necessary or advisable by my physician. I understand that local anesthetics do not always eliminate all pain, that in a small number of cases, patients can have an allergic reaction which could result in shock or even death.

I fully understand that the practice of medicine and surgery is not an exact science and that qualified physicians cannot assure the results thereof. I realize there are inherent risks of minor and major complications which many occur in this and all surgical procedures, without the fault of the physician. No guarantee has been made to me. I understand that the

surgical procedure which I am about to undertake will in all probability involve a certain amount of pain and loss of blood. I also understand that the surgical procedure which I have requested is occasionally accompanied or followed by certain complications including, but not limited to, perforation of the uterus (putting a hole through the uterine muscle), hemorrage, retainded tissue and/or infection, all of which could be severe enough to require surgery resulting in hysterectomy (removal of the uterus), and/or sterility (never being able to become pregnant again). If any of the above reactions or complication do ocurr, I further realize that I may need to be hospitalized which would be at my own expense. I realize that such complications can be caused by other medical conditions and not related to the pregnancy termination procedure, by my own failure to follow post-operative instructions, or by the treatment of the follow-up physician. I know that every effort is made to protect my confidentiality, but that if I have a medical problem that needs treatment, my confidentiality may be jeopardized.

I understand that any questions I have will be answered by my physician, nurse and/or counselor, and I will ask any questions I have before leaving. If I have any questions or complications after leaving, I agree to call the Allentown Women's Center at 215-264-5657. I realize that immediate treatment may be necessary to avoid more severe complications.

I understand the importance of post-operative follow-up care and I realize that I am responsible for scheduling a post-abortion check-up in 2-3 weeks to be certain that no medical problem has occured, that I may be unaware of, and to check that the procedure has been complete. I agree to report any and all post abortion problems to the

Allentown Women's Center, particularly fever, heavy bleeding, severe cramping or pain, or the absense of a normal period within eight weeks of the procedure.

I certify that I have read (or had read to me) and fully understand the above consent form, regarding termination of pregnancy, that the explanations therein referred to were made, and that all blanks or statements requireing insertion or completion were filled in. I further certify that all information I have supplied, in this entire record, is true to the best of my knowledge and belief.

DO NOT SIGN UNTIL YOU HAVE COMPLETELY READ AND FULLY UNDERSTAND THE ABOVE

SIGNATURE _____
WITNESS _____
DATE _____
I certify that I have explained, translated, or otherwise informed the patient of the above.
SIGNATURE _____
DATE _____
RELATIONSHIP TO THE PATIENT _____

DRUGS DISPENSED

I request that drugs not be dispensed to me in safety closure containers.
SIGNATURE _____
WITNESS _____
DATE _____

CONSENT TO ORAL CONTRACEPTIVES

I have chosen to use oral contraception as a birth control method and request the physician at Allentown Women's Center prescribe this method for me. I

understand the possible side effects to the method include severe headaches, leg cramps, blurred vision, blood clots, chest pain and stroke. I agree to report any and all side effects to Allentown Women's Center or to my own physician or clinic. I am aware that the most serious side effects of birth control pills can be fatal. I have read the information sheets and fully disclosed any risk factors in my medical history that might be contraindications to taking oral contraceptives.
SIGNATURE _____
WITNESS _____
DATE _____

CONSENT FOR RELEASE OF MEDICAL RECORDS

I give permission for release of information from my medical records from the Allentown Women's Center to my follow-up care provider and, if specified below, my referral source.

Referred by _____
SIGNATURE _____
WITNESS _____ DATE _____

Defendants' Exhibit 35:
AWC Advertisements

DONNELLY DIRECTORY

ALLENTOWN
WOMEN'S
CENTER

ABORTION SERVICES
AWAKE OR ASLEEP
EARLY PREGNANCY TESTS
GYNECOLOGICAL CARE
VD TESTING
ALL SERVICES CONFIDENTIAL

264-5657

Rt 22 & Airport Rd. Allentown

* * *

ALLENTOWN WOMEN'S CENTER
ABORTION SERVICES
AWAKE OR ASLEEP
EARLY PREGNANCY TESTING
CONFIDENTIAL COUNSELING

Rt 22 & Airport Rd Allentown
Toll Free ---- 800 372-8500

* * *

ALLENTOWN WOMEN'S CENTER--
- ABORTION SERVICES
- AWAKE OR ASLEEP
- SATURDAY HOURS AVAILABLE

Rt 22 & Airport Rd
Allentown Toll Free --- 800 372-8500

Defendants' Exhibit 36:
AWC Consent Form

I, _____, have requested an abortion at the Allentown Women's Center, although I have also stated I don't think abortion should be legally available to women.

I have been offered waiting time to reconsider my decision to abort this pregnancy. I have been offered genetic counseling, psychological counseling, and an explanation of the resources for financial and emotional support available to me to continue this pregnancy. I have been asked to consider how I expect to feel after an abortion, and urged not to take the irreversible step of terminating my pregnancy until I have fully processed the options before me.

I take full responsibility for my decision to terminate this pregnancy. I acknowledge and understand that my doctor here and the support staff are caring, responsible people who are helping me implement my voluntary, uncoerced request to terminate this pregnancy.

If in the future I ever publicly state that the Allentown Women's Center counseled me inadequately or that I was not fully aware of the gravity of what I was doing in terminating my pregnancy I understand that I will, by so doing, give up all rights to confidentiality and that the staff of the Allentown Women's Center will defend their non-directive counseling protocols publicly.

Signature _____
Date _____
Witness _____

Defendants' Exhibit 37:
Northeast Women's Center
Guidelines for Informed Consent

GUIDLINES FOR INFORMED CONSENT

I. Individual Counseling Session
  A. Exploration of all options
  B. Determination of Reason for Abortion
    1. to meet qualifications for abortion control act
    2. to assure that patient is sure of abortion decision
  C. Review of medical history to determine medical eligibility.
  D. Distribution of follow-up & after care instructions
  E. Distribution of birth control information
  F. Opertunity to explore feelings about abortion
  G. Completion of State Health Dept. form
    1. report of induced termination of pregnancy.

II. Group Counseling
  A. Explaination of abortion procedure
  B. Explaination of possible risks, and complications
  C. Explaination birth control methods.
  D. Explaination of written consent
  E. Signing of consent form
  F. Question and Answer

III. Physician Consultation
  A. Determination of reasons for abortion
  B. Question and answer period.
  C. Abortion procedure

Defendants' Exhibit 39:
Summary Compilation of Quarterly Reports

CUMULATIVE/YEARLY TOTALS: 1985 & 1986

Facilities: WHS, PPSP, WSC, AWC, RHCC

Conditions/ Indications	1985*	1986
Cardiac	59 (0.31%)	63 (0.30%)
Diabetes	27 (0.14%)	17 (0.08%)
Genetic	5 (0.03%)	5 (0.02%)
Hydatid Mole	7 (0.04%)	6 (0.03%)
Hypertension	40 (0.21%)	19 (0.09%)
Malignancy	5 (0.3%)	1 (0.005%)
Psych.	42 (0.22%)	29 (0.14%)
Radiation	11 (0.06%)	15 (0.07%)
Renal	--	--
Rubella	--	--
Incest	3 (0.016%)	23 (0.11%)
Rape	176 (0.93%)	276 (1.31%)
All Abortions	**18,999**	**21,029**

***Includes all date except 2nd Quarter of PPSP**

Defendants' Exhibit 45:
Commonwealth of Pennsylvania
Department of Health (DOH)
Abortion Facility Registration Form

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF HEALTH

ABORTION FACILITY REGISTRATION FORM

Effective April 24, 1988, every facility at which abortions are performed shall file this form within 30 days with the Bureau of Quality Assurance, Pennsylvania Department of Health, P.O. Box 90, Harrisburg, Pennsylvania 17108. Subsequent changes should be reported immediately, using this same form.

1. What is the name of your facility?

_____

2. What is the mailing address of your facility
   Street _____
   Post Office _____
   Zip Code _____

3. In what county is your facility located?

_____

4. Does your facility have any parent, subsidiary, or affiliated organizations, corporations, or associations?
   ____No ____Yes (If yes, list names and addresses below)
   a. Name_____ b.Name_____
   Address_____ Address_____

5. Does your facility have any parent, subsidiary or

affiliated organizations, corporations or associations which have contemporaneous commonality of ownership, beneficial interest, directorship or officership with any other facility? (If yes, list names and addresses below) ___No ___Yes

a. Name _____ b.Name _____
Address _____ Address _____
_____ _____

6. Registration forms filed by facilities which have received state appropriated funds during the 12 month period preceding a request to inspect or copy such forms shall be deemed public information. Has your facility received such funds? ___No ___Yes

7. Is this form an update of a previously submitted Registration Form?
___No ___Yes (List items and check type of update)
a. _____ _____ _____ _____
b. _____ _____ _____ _____
Change Add Delete

8. Date Submitted: _____
MO DAY YR

Defendants' Exhibit 46:
DOH Abortion Quarterly Facilities Report Form

COMMONWEALTH OF PENNSYLVANIA
Department of Health

ABORTIONS: QUARTERLY FACILITIES REPORT

Effective April 24, 1988, every facility in which an abortion is performed within Pennsylvania during any quarter year shall file a report with the State Health Data Center, Pennsylvania Department of Health, P.O. Box 90, Harrisburg, Pennsylvania 17108. Reports are due within 30 days of the end of the quarter.

1. Reporting Period (check one):
___Jan. 1 -- Mar. 31 ___Apr. 1 -- Jun. 30
___Jul. 1 -- Sep. 30 ___Oct. 1 -- Dec. 31

2. What is the name of your facility?
_____

3. What is the mailing address of your facility?
Street _____
Post Office _____
Zip Code _____

4. In what county is your facility located?
_____

5. How many abortions were performed in your facility in each trimester of pregnancy during the reporting period?

First Trimester: 0-14 weeks completed from the first day of last menstrual period _____

Second Trimester: 15-26 weeks completed from first day of last menstrual period _____

Third Trimester: 27 weeks or more completed from first day of last menstrual period _____

TOTAL ABORTIONS PERFORMED _____

6. Did your facility receive state appropriated funds within the 12 month period immediately preceding filing of the report? ___NO ___YES

Date Submitted _____
MO DAY YR

Defendants' Exhibit 47A:
DOH Report of Induced Termination of Pregnancy Form
(version no. 1)

FORMS MUST BE SUBMITTED TO THE PENNSYLVANIA DEPARTMENT OF HEALTH WITHIN 15 DAYS AFTER EACH REPORTING MONTH.

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF HEALTH

REPORT OF INDUCED TERMINATION OF PREGNANCY

1. FACILITY NAME _____
2. COUNTY OF PREGNANCY TERMINATION

_____

3. DATE OF PREGNANCY TERMINATION (Month, Day, Year)

_____

4. PATIENT'S IDENTIFICATION

_____

5. AGE LAST BIRTHDAY _____
6. MARRIED? ___YES ___NO

7a. RESIDENCE-STATE _____
7b. COUNTY _____

8. Of Hispanic Origin? (Specify No or Yes -- If yes, specify Cuban, Mexican, Puerto Rican, etc.) ____NO ____YES Specify: _____
9. RACE

___American Indian
___Black
___White
___Other (Specify) _____

10. EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) _____
College (1-4 or 5+) _____
11. DATE LAST NORMAL MENSES BEGAN (Month, Day, Year) _____
12. CLINICAL ESTIMATE OF GESTATION (Weeks) _____
13. PREVIOUS PREGNANCIES (Complete each section)

LIVE BIRTHS		OTHER TERMINATIONS	
13a Now Living	13b Now Dead	13c Spontaneous	13d Induced Do not include this termination
Number __ __None	Number __ __None	Number __ __None	Number __ __None

14. TERMINATION PROCEDURES
TYPE OF TERMINATION PROCEDURES
14a. PROCEDURE THAT TERMINATED PREGNANCY
(Check only one)
__ Suction Curettage
__ Sharp Curettage
__ Dilation and Evacuation (D&E)
__ Intra-Uterine Saline Instillation
__ Intra-Uterine Prostaglandin Instillation
__ Hysterotomy
__ Hysterectomy
__ Other (Specify) _____

__ Other (Specify) _____
14b. ADDITIONAL PROCEDURES USED FOR THIS TERMINATION, IF ANY
(Check all that apply)
__ Suction Curettage
__ Sharp Curettage
__ Dilation and Evacuation (D&E)
__ Intra-Uterine Saline Instillation
__ Intra-Uterine Prostaglandin Instillation
__ Hysterotomy
__ Hysterectomy
__ Other (Specify) _____
15. MEDICAL COMPLICATIONS OF PREGNANCY
__ Rubella
__ Hydatid Mole
__ Endocervical Polyp
__ Malignancies
__ Complication resulting from termination (Specify)
16. LENGTH AND WEIGHT OF THE FETUS
(Report only if termination subsequent to 19 weeks of gestation) Length_____cm Weight_____gm
17. DID A MEDICAL EMERGENCY EXIST? (Use back of form for explanations, if needed)
___YES Explain basis for judgment:
___NO Was the fetus viable prior to procedure? (Respond only if termination subsequent to 19 weeks of gestation)
___YES Explain basis for determination that the abortion is necessary, and the reason for selected termination procedure:
___NO Explain basis for determination of non-viability:
18. REFERRING PHYSICIAN, AGENCY, OR SERVICE (If any)
NAME _____

19. ATTENDING PHYSICIAN
Name _____
Licence Number _____
SIGNATURE AND DATE SUBMITED
_____Mo.__ Day__Yr.__

Defendants' Exhibit 47B:
DOH Report of Induced
Termination of Pregnancy Form
(version no. 2)

FORMS MUST BE SUBMITTED TO THE PENNSYLVANIA DEPARTMENT OF HEALTH WITHIN 15 DAYS AFTER EACH REPORTING MONTH

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF HEATLH

REPORT OF INDUCED TERMINATION OF PREGNANCY

1. FACILITY NAME
2. COUNTY OF PREGNANCY TERMINATION
3. PATIENT'S IDENTIFICATION (Do Not Use Patient's Name)
4a. RESIDENCE-STATE
4b. COUNTY
5. DATE OF PREGNANCY TERMINATION (Month, Day, Year)
6. AGE AT LAST BIRTHDAY
7. CLINICAL ESTIMATE OF GESTATION (Weeks)
8. PREVIOUS PREGNANCIES (Complete each section)

LIVE BIRTHS	OTHER TERMINATIONS

8a Now Living	8b Now Dead	8c Spontaneous	8d Induced (Do not include this termination)
Number __ ___None	Number __ ___None	Number __ ___None	Number __ ___None

9. TERMINATION PROCEDURES
TYPE OF TERMINATION PROCEDURES

9a. PROCEDURE THAT TERMINATED PREGNANCY

(Check only one)

__ Suction Curettage
__ Sharp Curettage
__ Dilation and Evacuation (D&E)
__ Intra-Uterine Saline Instillation
__ Intra-Uterine Prostaglandin Instillation
__ Hysterotomy
__ Hysterectomy
__ Other (Specify) _____

9b. ADDITIONAL PROCEDURES USED FOR THIS TERMINATION, IF ANY

(Check all that apply)

__ Suction Curettage
__ Sharp Curettage
__ Dilation and Evacuation (D&E)
__ Intra-Uterine Saline Instillation
__ Intra-Uterine Prostaglandin Instillation
__ Hysterotomy
__ Hysterectomy
__ Other (Specify) _____

10. MEDICAL COMPLICATIONS OF PREGNANCY

__ Rubella

__ Hydatid Mole
__ Endocervical Polyp
__ Malignancies
__ Other Complications Resulting From Pregnancy (Specify)
__ Complication Resulting From Termination (Specify)

11. ATTENDING PHYSICIAN
Licence Number

12. SIGNATURE AND DATE SUBMITTED
_____MO__DAY__YR__

Defendants' Exhibit 47C:
DOH Report of Induced
Termination of Pregnancy Form
(version no. 3)

FORMS MUST BE SUBMITTED TO THE PENNSYLVANIA DEPARTMENT OF HEALTH WITHIN 15 DAYS AFTER EACH REPORTING MONTH.

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF HEATLH

REPORT OF INDUCED TERMINATION OF PREGNANCY

1. FACILITY NAME _____
2. DATE OF PREGNANCY TERMINATION

_____
(Month, Day, Year)

3. PATIENT'S IDENTIFICATION
(Do Not Use Patient's Name) _____
4. AGE LAST BIRTHDAY _____
5a. RESIDENCE-STATE _____
5b. COUNTY _____
6. DATE LAST NORMAL MENSES BEGAN

_____
(Month, Day, Year)

7. Of Hispanic Origin? (Specify No or Yes -- if yes, specify Cuban, Mexican, Puerto Rican, etc.)
__NO __YES Specify: _____
8. RACE
__American Indian
__Black
__White
__Other (Specify) _____

9. EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) _____
College (1-4 or 5+) _____
10. MEDICAL COMPLICATIONS
___ Pre-existing medical conditions which would complicate pregnancy (Specify)
___ Complication resulting from termination (Specify)
11. PREVIOUS PREGNANCIES (Complete each section)

LIVE BIRTHS		OTHER TERMINATIONS	
11a Now Living	11b Now Dead	11c Spontaneous	11d Induced (Do not include this termination)
Number __ __None	Number __ __None	Number __ __None	Number __ __None

12. TERMINATION PROCEDURES
TYPE OF TERMINATION PROCEDURES
12a. PROCEDURE THAT TERMINATED PREGNANCY
(Check only one)
__ Suction Curettage
__ Sharp Curettage
__ Dilation and Evacuation (D&E)
__ Intra-Uterine Saline Instillation
__ Intra-Uterine Prostaglandin Instillation
__ Hysterotomy
__ Hysterectomy

__ Other (Specify) _____

12b. ADDITIONAL PROCEDURES USED FOR THIS TERMINATION, IF ANY

(Check all that apply)

__ Suction Curettage
__ Sharp Curettage
__ Dilation and Evacuation (D&E)
__ Intra-Uterine Saline Instillation
__ Intra-Uterine Prostaglandin Instillation
__ Hysterotomy
__ Hysterectomy
__ Other (Specify) _____

13. CLINICAL ESTIMATE OF GESTATION AT TIME OF THE ABORTION*

(Weeks)_____

DETERMINATION OF GESTATIONAL AGE

Types of inquiries/examinations/tests utilized:

_____

Basis for diagnosis: _____

14. DID A MEDICAL EMERGENCY EXIST?

__NO __YES

Explain basis for judgement below.

_____

15. Was patient married? __YES __NO

IF YES, WAS NOTICE GIVEN TO THE SPOUSE? __YES __NO

IF NO, CHECK REASONS FOR NO NOTIFICATION

___ Spouse is not father of child.
___ Spouse, after diligent effort, could not be located.
___ Pregnancy was result of a spousal sexual assault which was reported to a law enforcement agency.
___ Patient had reason to believe that furnishing of notice would likely result in the infliction of

bodily injury by her spouse or another individual.
___ Medical Emergency.

16. REFERRING PHYSICIAN, AGENCY, OR SERVICE (If any)

NAME: _____

17. ATTENDING PHYSICIAN

Name_____

Licence Number _____

SIGNATURE AND DATE SUBMITTED

_____MO__DAY__YR_____

*IF GESTATIONAL AGE IS 24 WEEKS OR MORE, COMPLETE REVERSE OF FORM.

COMPLETE FOLLOWING ITEMS ONLY IF GESTATIONAL AGE IS 24 WEEKS OR MORE

18. BASIS FOR THE JUDGMENT THAT ABORTION WAS NECESSARY TO PREVENT THE PATIENT'S DEATH OR SUBSTANTIAL AND IRREVERSIBLE IMPAIRMENT OF A MAJOR BODILY FUNCTION.

_____
_____
_____
_____
_____

19. NAME OF CONCURRING PHYSICIAN

_____

20. NAME OF SECOND PHYSICIAN IN ATTENDANCE _____

21. WEIGHT OF ABORTED FETUS

_____gm

Defendants Exhibit 48:
DOH Certification Regarding
Spousal Notice Form

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF HEALTH

ABORTIONS: SPOUSAL NOTICE

CERTIFICATION REGARDING SPOUSAL NOTICE

I understand that as a married woman, I am required to notify my spouse of the fact that I am about to undergo an abortion, prior to obtaining such abortion, unless I am exempt from the notification requirements due to one of the reasons set forth below. Pursuant to this requirement, I hereby certify that:

CHECK APPROPRIATE BLANK(S)

_____ I have notified my spouse that I am about to undergo an abortion.

_____ I have not notified my spouse that I am about to undergo an abortion for the following reasons(s):

- _____ My spouse is not the father of the child.
- _____ My spouse, after diligent effort, could not be located.
- _____ The pregnancy is a result of spousal sexual assault which has been reported to a law enforcement agency having the requisite jurisdiction.

- _____ I have reason to believe that the furnishing of notice to my spouse is likely to result in the infliction of bodily injury upon me by my spouse or by another individual.

I understand that any false statement made herein is punishable by law.

_____
Signature/Date

NOTICE: ANY FALSE STATEMENT MADE HEREIN IS PUNISHABLE BY LAW.

Defendants' Exhibit 49:
Excerpts from DOH Directory of Social Service Organizations for Referrals for Pregnant Women

COMMONWEALTH OF PENNSYLVANIA

DEPARTMENT OF HEALTH

DIRECTORY OF SOCIAL SERVICES ORGANIZATIONS

JULY, 1990

The agencies listed provide a variety of services which may assist a woman through pregnancy, upon childbirth, and while the child is dependent. Private physicians, clinics, and hospitals may also offer these services.

Examples of services which may be provided directly, or by referral, include but are not limited to counseling, pregnancy testing, medical care, legal and financial assistance, transportation, childbirth instruction, housing, job placement, continuing education and adoption information. Where the agency offers primarily a specialized service, it has been noted. "Special Services" have been numerically coded according to the following index:

01- Abuse (Drugs, Domestic, Child)
02- Adoption
03- Book Resources on Childbirth (Childbirth Instruction)
04- Clothing
05- Counseling (Job, General, Psychological, Prenatal, Family)
06- Emergency Assistance
07- Food
08- Food Stamps
09- Fuel
10- Furniture
11- Hot Line Services
12- Interpreting Services
13- Job Training/Placement
14- Legal Referral
15- Nutrition
16- Information & Referral
17- Schooling/Education
18- Shelter/Housing
19- Short-term Crisis Intervention
20- Teens
21- Telephone Referral
22- Transportation
23- WIC (Women, Infants and Children) Nutrition Program
24- Foster Care
25- Financial Assistance
26- Medical Care/Testing
27- Family Planning
28- Day Care

* * *

Defendants' Exhibit 50:
Excerpts from DOH Printed Information on Medical Assistance Benefits

COMMONWEALTH OF PENNSYLVANIA

DEPARTMENT OF HEALTH

MEDICAL ASSISTANCE BENEFITS FOR PRENATAL CARE, CHILDBIRTH AND NEONATAL CARE

JULY, 1990

You may or may not qualify for medical assistance benefits, depending on your income. For persons who qualify, the Medical Assistance Program will pay for doctor, clinic, hospital, and other related medical expenses so you can receive prenatal care, delivery services, and care for your newborn baby. You can apply for Medical Assistance benefits at your local County Assistance Office.

Under the Healthy Beginnings Program you may be eligible for Medical Assistance because you are pregnant. A pregnant woman is allowed to have more income to qualify for this benefit and may receive prenatal care from certain providers while the formal application for assistance is being processed.

Your County Assistance Office can tell you which providers participate in the Medical Assistance Program and can answer your questions about other available

benefits. County Assistance Offices are listed for your information. The attached pamphlets on Medical Assistance and Healthy Beginnings also may be of assistance to you.

• • •

If you are pregnant or have children three years old or younger, **Healthy Beginnings** could provide you free health care for yourself and your children.

In October 1989, this program will be expanded to include children up to four years old.

If you or your family's income is less than or equal to the chart on the back of this card, you should call, toll-free **1-800-842-2020**, or contact your local county assistance office.

FAMILY SIZE	MONTHLY INCOME GUIDE
one person	$ 498
two persons (or a pregnant woman)	$ 668
three persons	$ 838
four persons	$1,008
five persons	$1,178
six persons	$1,348

If your income is close to these figures, call **1-800-842-2020**. We may still be able to help you.

Healthy Beginnings covers all your health care needs including prescriptions, dental care, physician, delivery and other necessary hospital costs.

If you think you quality for **Healthy Beginnings**, call **1-800-842-2020,** today!

* * *

FACTS

MEDICAL
ASSISTANCE
CAN
HELP

THIS BROCHURE CONTAINS SOME BASIC INFORMATION ABOUT MEDICAL ASSISTANCE. PLEASE READ IT CAREFULLY, IT WILL TELL YOU WHAT TO BRING WITH YOU WHEN YOU APPLY.

Commonwealth of Pennsylvania
ROBERT P. CASEY
GOVERNOR

Department of Public Welfare
JOHN F. WHITE, JR.
SECRETARY

OFFICE OF MEDICAL ASSISTANCE

REMEMBER --
MEDICAL ASSISTANCE
CAN HELP!

The Medical Assistance program is designed to help you pay doctor, hospital, and other medical-related expenses so you and your family can receive continuing medical and dental care when your medical and dental costs are higher than you can afford.

This brochure contains some basic information about Medical Assistance. **Please read it carefully. It will tell you what to bring with you when you apply.**

If you do have any questions, please call your local county assistance office. They want to help.

Note: Some counties may be using health maintenance organizations (HMOs) or health insuring organizations (HIOs) in addition or in place of the regular Medical Assistance Program. If you live in one of these counties, your local county assistance office will be able to explain these other programs to you.

Facts About Medical Assistance

- You can apply for Medical Assistance in the county where you live in Pennsylvania.
- You can work, and still may be able to get Medical Assistance.
- You can own a house and have a car and still get Medical Assistance.
- You don't have to get a welfare check to get Medical Assistance.
- You don't have to live with children to get Medical Assistance.
- You can be getting social security, unemployment or some other kind of income and still may be eligible for Medical Assistance.

Persons who are eligible for Medical may be eligible for some services under Medical Assistance which medicare does not cover. However, Medical Assistance does not automatically pay the difference between a medical provider's charge and the Medicare payment.

How Does Medical Assistance Work?

If you are eligible for Medical Assistance, you may go to a doctor, hospital, or other health-care provider for medical services. If the health-care provider participates in the Medical Assistance Program, and if you have no other medical insurance which will cover the medical service, the State will pay for the medical service.

Some services require prior authorization by the state Office of Medical Assistance. A brochure entitled **Prior Authorization of Medical/Dental Services** explains this.

Please note that payments are made to the **provider** not to the **patient**.

You may be asked to pay a small amount to the provider for the service. This is called a co-pay. Ask

your county assistance officer for the brochure **What is Co-Pay?**, which explains how co-pay works.

Out-of-State Services

The Department will pay for medical services furnished to you while out of of state if:

- You require emergency medical care while temporarily away from your home.
- You would be risking your health if you wait for the service until you returned home
- You live in a state border area and recipients in your area regularly use medical resources in a neighboring state.
- The Department decides, based upon the medical provider's advice, that you have better access to the type of medical service you need in another state.

Who Can Receive Medical Assistance?

There are three categories of Medical Assistance. You may be eligible for one of them:

1) Categorically Needy: This is for persons who are eligible for cash assistance, or for people who receive Supplemental Security Income (SSI). These persons receive a **blue** Medical Assistance card.

2) Medically Needy Only: Ths is for persons who are not eligible for cash assistance or SSI but whose income is not enough to cover their medical expenses. These persons receive a **green** Medical Assistance care.

3) State Blind Pension: This is for persons who are eligible for and receive a check from the State Blind Pension Program. These persons receive a **pink**

Medical Assistance card.

Ask your county assistance office for **Services Covered by the Medical Assistance Card**. This shows the benefits covered by each of the three Medical Assistance categories.

How Do I Apply for Medical Assistance?

You must file an application with you local county assistance office. You may pick up your application at the local county assistance office or phone the office and have one mailed to you.

If you are unable to apply for yourself, a relative, friend, hospital representative or other person may apply in your behalf.

When you return the application to your county assistance office, a worker will look over your application with you to make sure you have completed all items. The worker will help you complete the application if you need help. If there is some information you are not able to get, your county assistance office can help you to get this information.

When you apply for Medical Assistance, you will need to provide information about yourself and your family to help the county assistance office decide what kind of help you can receive. **It you don't have it on hand, apply anyway.**

You will need:

- Birth certificates and other forms of identification for yourself and other family members in your home, such as a driver's license or school or work identification.
- Your social security card and social security cards for other persons in the home for whom you are applying (your worker can help you apply for these if you do not have them).
- Letters or forms that show how much money you and other family members living in the home get from social security, Supplemental Security Income (SSI), Veteran's pensions, unemployment compensation, worker's compensation, retirement or other kinds of income.
- Wage stubs (if you are working) and wage stubs for other family members living in the home who are working.
- Health and medical insurance policies and bank books, savings books and any other records to show how much money you and other family members living in the home have available.
- Life insurance policies.

Your worker can tell you what additional information you will need to be eligible for Medical Assistance and help you to get this information.

After your worker determines that you are eligible for Medical Assistance, you will receive a Medical Assistance Card which is good through the date shown on the card. You will receive a new card before the old one expires. **If you card is lost, stolen or destroyed, tell your county assistance office immediately.** They will replace it so you don't have to miss any medical appointments.

As a recipient, you have certain rights and responsibilities. A pamphlet titled **Your Rights and Responsibilities in Public Assistance Programs** describes them.

How Do I Find a Medical Provider Who Will Accept the Medical Assistance Card as Payment?

First, check with your present doctor, dentist or

other medical provider to see if the Medical Assistance card will be accepted. If not, you may want to ask someone you know who receives Medical Assistance for the name of a doctor or dentist.

If you cannot find a doctor or dentist who accepts the Medical Assistance card, contact your caseworker at the local county assistance office, who will help you locate a medical provider who accepts the card.

What If I Don't Agree With the Decision of the County Assistance Office?

If the county assistance office determines that you are not eligible for the Medical Assistance Program, you will receive a notice from your county assistance office. You have the right to appeal the decision and request a fair hearing. If you are already receiving medical assistance and if you appeal within 10 days from the date of the notice, your Medical Assistance coverage will continue pending the outcome of the fair hearing.

Your county assistance office is there to help you. You should call them with questions you may have about Medical Assistance eligibility or coverage.

The Mission of the Department of Public Welfare is to:

Promote, improve and sustain the quality of family life,
Break the cycle of dependency,
Promote respect for employees
Protect and serve Pennsylvania's most vulnerable citizens, and

Manage our resources effectively.

Defendants' Exhibit 51:
DOH Notices Required by
Abortion Control Act

COMMONWEALTH OF PENNSYLVANIA

DEPARTMENT OF HEALTH

NOTICES REQUIRED BY
ABORTION CONTROL ACT

JULY, 1990

1. It is generally unlawful for any individual to coerce a woman to undergo abortion.

2. Any physician who performs an abortion upon a woman without according her a private medical consultation may be liable to her for damages in a civil action at law.

3. The father of a child is liable to assist in the support of that child, even in instances where the father has offered to pay for an abortion. The availability of support payments will depend, in part, on the father's income. You may wish to consult with a lawyer regarding the availability of support payments.

4. The law permits adoptive parents to pay costs of prenatal care, childbirth and neonatal care.

Defendants' Exhibit 54:
Deposition Excerpts of
Thomas E. Allen, M.D.

BY MS. MERSHIMER:

• • •

[9] Q. While you've been at Magee, have you performed any abortions because there was a medical emergency?

A. No.

Q. How about at WHS?

A. Not -- no.

• • •

[13] Q. All right. Now, Exhibit B attached to Defendants' Exhibit 1 is Magee's informed consent form?

A. Informed consent, correct.

Q. And this, you make sure every patient signs?

A. Reads this and signs it, or has it read to her if she can't understand it.

Q. Now, in cases of a minor, do you have the parent sign it, also?

A. It's required by Magee. There's no question about it. You can't do an abortion there without having the parent's consent.

Q. Does Magee require a parent's consent of a non abortion surgical procedure, also?

A. Yes. Everything except delivery of term -- or a delivery.

• • •

[28] Q. Now, Interrogatory 15, I had asked you

about the allegations in the Complaint that the Act unduly restricts a woman's access to counseling, and you refer to various verifications in your Answer?

A. I think that was my attorney's --

MR. ZEMAITIS: Yes. I don't think there's any obligation under the Federal Rules of Civil Procedure or otherwise that every plaintiff be able to state from his or her own personal knowledge facts that support a particular allegation of the Complaint.

MS. MERSHIMER: I'm not saying that there is.

[29] A. Yes.

Q. My question to you is: Do you have any knowledge upon that aspect of the Complaint, that allegation?

A. No, I do not.

• • •

[71] Q. Have you ever performed an abortion on anyone without having their informed consent?

A. No.

Q. So that would include both adults and minors?

A. Right.

• • •

[78] Q. Excluding abortion, would you ever perform a surgical procedure on somebody without their informed consent?

A. No.

Q. And, again excluding abortion, would you ever perform a surgical procedure on a minor without the consent of a parent?

A. No. Probably not. I can't think of -- except an emancipated minor who is not considered to be a minor. A woman who -- a teenager who has a child is not

considered a minor for any operative procedure, except as defined by this Act.

Q. Okay. Let's just clarify the question, then. Again excluding abortion, would you ever perform a surgical procedure on an unemancipated minor without the consent of the parent?

A. No. But by my definition, a person who is pregnant is emancipated to some degree.

Q. That's your personal definition.

[79] A. That's my personal definition, yes.

• • •

Defendants' Exhibit 55:
Deposition Excerpts of Sue Roselle

* * *

[7] Q. In Paragraph 2 of your verification, you [8] talked about the staff you're responsible for, and you mentioned 13 physicians.

A. Yes.

Q. Is that still the same number of physicians currently being used by WHS?

A. I believe we have 12 physicians currently.

Q. And Dr. Allen this morning said that all the physicians are part-time.

A. That's correct.

Q. Is there any approximate hours that they work?

A. There is one physician who works approximately 20 hours a week, and then everyone else is what we call as-needed, which is when we schedule them.

Q. And you perform abortions at WHS three days a week?

A. That's correct.

Q. For the most part, counseling occurs the same day as the abortion service --

A. That's correct.

Q. -- is provided? It's more difficult for her to take us down when I'm still asking a question [9] and you answer. I understand how it is. I have the same habit. Also, the record reads a little easier.

What, it's like 95 percent of all the counseling occurs on the same day the abortion services are provided?

A. Approximately 95 percent.

* * *

Q. In Paragraph 6, which would be on Page 3, it

lists the prices of the abortion procedure costs depending upon how late the pregnancy we're talking about?

A. That's correct.

Q. Have those prices changed since you initially filled out this verification?

A. Yes, they have.

[10] Q. Could you tell me what the new prices are?

A. $295 if 12 weeks or less; $395 if 13 to 14 weeks; $600 if 15 to 16 weeks; and $625 if 17 weeks.

Q. And no abortions after 17 weeks gestation --

A. That's correct.

Q. -- are performed at WHS; is that correct?

A. That's correct.

Q. Is there any particular reason why the prices went up, anything you can attribute it to?

MR. ZEMAITIS: You mean other than general economic trends?

MS. MERSHIMER: Right.

Q. Other than like labor costs went up or --

A. No.

* * *

[17] Q. . . . . WHS still encourages minors to bring a parent or another adult with them?

A. That is correct.

Q. Is your preference to have a parent?

A. That's correct.

Q. Is there a reason why you like the parent to attend with a minor?

A. To encourage family communications.

Q. If a minor calls up, when she first telephones, is that when it's encouraged, the minor is encouraged to bring her parent along?

A. Yes.

* * *

[20] Q. And the paraprofessional counselors, there's no education requirement to be a paraprofessional counselor?

A. That's correct.

* * *

Q. And what's covered during this counseling interview is a discussion about her options, her decision to have an abortion, make sure she's not unduly ambivalent about what she's doing and make sure she's not being coerced to have an abortion and [21] to talk about future contraceptive use. Is that pretty much it?

A. That's it.

Q. This next line talks about if a patient appears ambivalent about her decision and the abortion is rescheduled to give her more time to consider her options.

A. That's correct.

* * *

Q. And then the personal counselor is what? It's a more intense discussion, or what?

A. The personal counselor is prepared to at least masters degree level and has five years post masters experience in therapy, and it focuses on the pregnancy as a problem in relationship to the rest of the factors in her life.

* * *

[22] Q. When a parent does attend, does both the minor and the parent sign the informed consent form?

A. That's correct.

* * *

[43] Q. In Paragraph 35, you discuss your concern about putting the identity of the referring [44] performing physicians in a report to the Department of Health, and then you state, "I can state with complete certainty that because of the harassment and violence directed toward physicians who refer or perform abortion procedures, WHS will lose many of its referring physicians and possibly some of its performing physicians if this section goes into effect." Now, focusing on performing physicians, that information is being provided on the reports currently.

A. That's correct.

Q. And have you lost any performing physicians for that reason?

A. We have lost a couple of physicians. They have not given that reason for them leaving. The rest of the physicians have continued to express a lot of concern about that information becoming available to the public.

* * *

[79] Q. I take it from your response to Interrogatory No. 24 on Page 18 that WHS advertises in some local newspapers in the Pittsburgh area, on radio stations, and some college newspapers and also in the phone book?

A. That's correct.

* * *

[80] Q. I'm looking at Interrogatory No. 2 on Page 3 focusing on WHS' Answer. Remember you said you weren't sure of the percentages of minors that are

accompanied by an adult? Does that refresh your recollection, 75 percent of the minors are accompanied by an adult?

A. Yes.

Q. And that on the next page, that 50 percent of the minors are accompanied by one or both of their parents?

A. That's correct.

Q. Now, when a minor is accompanied by an adult, not necessarily their parent, does that adult participate or is involved at all in any part of the counseling or informed consent aspect?

[81] A. No.

Q. But if the minor is accompanied by one of the parents, then the parent is involved in part of that counseling session, and particularly as to informed consent?

A. That's correct.

• • •

[84] Q. When I asked you if any of the physicians that had left WHS was because their identity, performing physician's identity was listed on the reports to the Department of Health, you said that wasn't the reason they gave you?

A. That is not the reason they gave me.

Q. Did any of the reasons they gave you have [85] to do with any of the requirements of Pennsylvania law?

A. No.

• • •

Defendants' Exhibit 56:
Deposition Excerpts of Carol C. Wall

BY MS. MERSHIMER:

• • •

[10] Q. And abortions at the Center City Clinic still occur on Wednesdays, Thursdays, Fridays, and [11] Saturdays?

A. Yes.

Q. And what are the general hours of the clinic then?

A. They are regular medical clinic hours. Abortions would be performed approximately four to five hours each of those days.

• • •

[12] Q. Now, the cost that you stated in your Verification of an abortion in the first trimester if they were not on Medical Assistance was $225.

Does that still remain the price?

A. No.

The price now is $240.

Q. Is there any specific reason why the price has gone up?

A. Yes.

The costs have gone up.

Q. What?

A. The costs of salaries and non-salary costs have gone up.

Q. Supplies and things like that?

[13] A. Yes

Q. And I see here that the fees cover the direct cost of the procedure, including counseling, medical testing, and examination, and abortion procedure, medical

supervision during the post-surgical recovery, and post-abortion examination?
A. That's correct.

* * *

[14] Q. When you said the direct cost, which is now $240, covers these various procedures, do you know how much of that charge covers the cost providing personal counseling?
A. No.

The salaried costs are broken down at some point when we are figuring what we have to [15] charge in order to cover our costs, but I don't know exactly how much the counseling part of it would be.

* * *

[16] Q. At Planned Parenthood are any abortions [17] performed because there is a medical emergency?
A. I would say no.

Could you be more specific on what medical emergency means to you?
Q. Well, there are two definitions of medical emergency that have been used in this lawsuit. One is the medical emergency definition that is contained in the Act.
A. Yes.
Q. And then the other definition of medical emergency is that which was provided by the Plaintiffs in response to Interrogatories, which give me a second and I will find it here. It was in response to Interrogatory NO. 18 where the Plaintiff said, "A medical emergency occurs whenever, in the judgement of the attending physician, a combination of circumstances presented requires immediate medical attention to protect the life or the health of the patient."

A. Yes; then my answer is definitly no as I said before.
Q. No as to either definition?
A. Yes.

* * *

[18] Q. Now, Planned Parenthood encourages minors to involve their parents in the decision to have an abortion; correct?
A. Yes.
Q. Do you encourage a minor to bring the parent along to the procedure if the parent is agreeable?
A. Yes.
Q. Why does Planned Parenthood do that?
A. Our experience is that very young women need to have the help and support of their family members and want it.
Q. If a parent does attend with the minor, does the parent also sign the Informed Consent Form?
A. No.

* * *

[20] Q. So you contract with the physicians?
A. Yes.
Q. How many physicians do you contract with?
[21] A. At this time three to four different physicians.

* * *

[24] Q. The counselors for Planned Parenthood, is there any minimum education requirement?
A. No.
Q. Are there any sort of certificates or degrees that they have to have?
A. No.

Q. But they must attend the training program at Planned Parenthood?
A. Yes.
Q. Could you tell me about the training program?
A. The training program is mainly in-service at the beginning of the time that they start working with us, and it is carried out by the clinical staff, the management of the clinical [25] staff.
Q. Is there any length of time that this in-service training occurs?
A. I don't know. It varies with the individuals and their backgrounds. I do know that.

We do have some people who have Master's degrees in counseling and some have Bachelor's degrees who have had a major in a field that's related. And we have some people who have not had that kind of formal training.
Q. You had said that the number of counselors you have varies on how many procedures are being performed?
A. Yes.
Q. You mean how many counselors you have coming in on any given day?
A. That's correct.
Q. How many counselors do you have as a pool to use?
A. I don't know.
Q. Is it more than ten?
A. No.

I would say fewer probably.
[26] Q. And they are all paid or are there any volunteers?
A. There are some volunteers, yes.
Q. The ones that are paid, what is their salary?
A. I don't remember.
Q. Well, do you know the starting salary?
A. No.

It would be around $15,000, $16,000 a year annualized, but I'm not sure.

* * *

[66] Item NO. 3 that states "all counseling is confidential (within legal limitations) and will be conducted in privacy."

MR. CIPOLLA: Where is this?
BY MS. MERSHIMER:
Q. I'm sorry, the second page of Exhibit-A.
A. Okay, thank you. You want to know -- what is your question?
Q. I just wanted to see, first of all, if you found that statement.
A. Yes, I have it.
Q. What are the legal limitations? I just didn't know that there were any ones that affect counseling. What is meant by that?
A. The one that I recall is that in the cases -- in a case of, I believe, it's rape or incest of a minor, our facility just, as any other helping facility, is required by law to report that to the municipality in which our facility is located. That is one.

* * *

[71] Q. There is a section on the bottom of this form requiring physicians to sign for minors under the age of 18 without parental consent; is that correct?
A. Yes.

* * *

Defendants' Exhibit 57:
Deposition Excerpts of Sherley Hollos

BY KATE MERSHIMER:

• • •

[4] A. I'm the Executive Director of Women's Suburban Clinic.
Q. Could you tell me what your job duties include as Executive Director?
A. Well, I am responsible to the Board of Directors. We are a 501C3, so all my department heads report to me and I'm responsible for the overall management of the clinic.

• • •

[7] Q. Now, abortions are performed at Women's Suburban Clinic on Tuesdays, Wednesdays, Thursdays during afternoon and early evening hours?
A. That's correct.
Q. And that is still the current situation?
A. Yes.
Q. Would you have any problem, as I ask you questions, if I refer to Women's Suburban Clinic as WSC?
A. No problem.
Q. Is there any other sort of shorthand form you use?
A. That's what we always call it, WSC.
Q. Now, how many physicians are there at WSC?
A. There are two physicians that practice at WSC.
[8] Q. And do they both work those Tuesday, Wednesday, and Thursday hours?
A. There is one physician present each day.

• • •

[11] Q. Now, the nurse practitioners, the RNs and the LPNs, do they do any counseling?
A. Not exactly, but a nurse by definition deals with the whole person. It's a matter of definition of what you call counseling.
Q. Well, is it fair to say that what you are talking about with the nurses, if they are going through the procedure, whenever there are questions presented by the patients, they are going to take the time to answer those questions?
A. Certainly, but a nurse is not a counselor in that they do the formal counseling prior to the procedure.

• • •

[12] Q. And the fee was $225 at the time of the Verification.
Is that still the same?
A. It's $245 now.
Q. Is there any particular reason why that fee rose?
A. Inflation.
Q. Basic cost of salary increase and supplies, thing like that?
A. Yes.
And extra papers that we have to deal with.
Q. The extra papers being the reporting forms of the State, the Department of Health?
[13] A. Yes.
Q. Do you know how much of that $20 increase is due to the extra reporting provisions versus just the standard cost of salaries going up?
A. No, I don't.

• • •

[19] Q. Now, minors are all encouraged to come in for

precounseling; is that correct?
A. That's correct; if they are not coming with their parent.
Q. And WSC encourages the parents to come; is that correct?
A. Yes.
Q. Why is that?
A. Because it's important for any woman having an abortion to have a support system beyond the clinic. And for a minor the obvious support system is the parent.

• • •

[20] Q. Now, is that the form, the Certification by Patient, that any patient must sign prior to having an --
A. Every patient must sign.
Q. That is to have an abortion?
A. Yes.
Q. And this is the form where they acknowledge that they were told about the risks of [21] the abortion and alternatives to abortion?
A. Yes.
Q. Now, if a minor has an abortion, that minor has to sign that form?
A. I believe so. I am not a counselor. I know that you have to sign the next form, the Parental Involvement Form.
Q. If the parent comes with their minor to the clinic, do they have to sign any forms?
A. Yes; then they sign the Parental Involvement Form to the "or," "I am the parent and guardian and I am aware of her decision to abort."
Q. Is this the way it works with the minor; if the minor comes alone and doesn't want to involve their parents, they sign this first paragraph of the Parental Involvement

Form?
A. Yes.
Q. And if the parent or guardian does come with the minor, then that parent or guardian must sign the second paragraph of the Parental Involvement Form?
A. That's correct.
Q. And then if the parent or guardian does know about the abortion but was unable to attend, [22] then, again, the minor would sign the last paragraph?
A. Correct.
Q. And then there is a third form called Physician's Certification?
A. Yes.
Q. All doctors have to sign that form?
A. Yes.
Q. Is that in the case of any patient or just minors?
A. Any patient.
Q. And are there any times where a physician refuses to sign this form?
A. Not to my knowledge.

• • •

[30] Q . . . . When we initially got onto the exhibit, we were talking about minors coming in for precounseling prior to the abortion appointment?
A. Yes.
Q. Do most minors do that, come in for the precounseling session?
A. Most -- I don't know statistically how many do, but that's a question that is always asked.
Q. It says here that the minors are asked to come in for precounseling, but it is not a requirement; is that correct?
A. All minors who have not informed a parent come in for precounseling.

Q. So they must come in for precounseling?
A. Yes; unless there are very extenuating circumstances.
[31] Q. Do such minors that come in for precounseling because they have not informed a parent, do they ever change their mind and then bring their parent to the abortion --
A. Yes.
Q. Do you know how much of a period of time there is between the precounseling session and the abortion appointment?
A. It depends. It could be anywhere from the night before to more time.
Q. A week or two weeks?
A. It would be dependent on their LMP date. How much, you know, how much time there is.
Q. So if they are in their thirteeth week of LMP, if they are going to have the abortion performed at WSC, there is not much time to wait?
A. That would be a good example.

* * *

[33] A. . . . . The only thing that isn't explicit -- is explicitly discussed is the alternative to having an abortion, but you can see that that happens because in the Disclosure of Risk Benefits and Alternatives it is gone over orally. And they are given that piece of paper, the Consent Form, before they see the counselor and asked to read it but not to sign it so that they have time to read it before sitting down in the counseling session.

* * *

[40] Q. And is it still Women's Suburban's estimate that if the Parental Consent Provision goes into effect it would require at least additional three-quarter time

counseling positions at a cost of about $15,000 per year?
A. I think that is accurate.

* * *

[44] Q. Now, that part of the law that requires the performing physician's identity to be submitted to the Department of Health, since that has gone into effect have you known of any doctors who perform abortions that have stopped performing abortions because their identity is on that form?
A. I don't know of any personally.

Defendants' Exhibit 58:
Deposition Excerpts of Jane S. Green

BY MS. MERSHIMER:

• • •

[8] Q. First trimester abortions, the price listed in, I think it is an April '88 Verification, list the price as two hundred and ten dollars, is that still the price?
A. It remains the same.

• • •

Q. How about for early second trimester abortions; is it still three sixty-five?
A. That's correct.

• • •

[12] Q. Are abortions still performed on Wednesday and Friday afternoons and Saturday mornings?
A. On Saturday mornings, not at this point; Wednesday and Friday and Tuesday.
Q. Tuesday, all day Tuesday?
A. Tuesday afternoon.
Q. Is Wednesday just Wednesday afternoon or all day Wednesday?
A. Wednesday evening. So that is wrong. That says Wednesday from ten to three, so it is Wednesday evening.

• • •

[20] Q. Now, paragraph eleven of your Verification,

approximately in the middle, there is a discussion, "If the woman already has had a postive test when she calls RHCC and wants to terminate her pregnancy, an abortion appointment can be scheduled usually within one week's time."
Is that still correct information?
A. That is correct information.
Q. Does it ever take more than a week to schedule the abortion appointment?
A. Sometimes. It depends upon her medical history. There are certain questions that telephone counselors ask, in terms of medical history. And if the woman needs to obtain a physician's note, then it could take longer.

• • •

[23] Q. Now, RHCC encourages parental involvement in the abortion decision; is that correct?
A. What do you mean, in terms of that?
Q. I was just reading paragraph eighteen, it says, "In general, RHCC supports and encourages parental involvement in the abortion decision where possible."
A. That's correct.
[24] Q. Why is that?
A. Well, we feel that it is important because when the minor goes back into her home, that the parent will have a better understanding perhaps of what the minor is going through. Unfortunately, that is not always the case. But that is primarily the reason why we would want that support from the parent. We only can give short term relationship counseling and we can't go back with that person.
Q. Just to go back for a minute, you said that the parent, when he or she accompanies a minor does not attend the group session that goes over the risks and the

informed consent provision.
A. That's correct.
Q. So is the parent ever advised?
A. That's why we have the waiting room counselling, that's then when the waiting room counselor would do that with the parents.
Q. The waiting room counselor would advise the parents of possible complications?
A. That's correct.

• • •

Defendants' Exhibit 59:
Deposition Excerpts of Sylvia Stengle

BY MS. MERSHIMER:

• • •

[6] Q. You are the executive director of Allentown Women's Center?
A. Yes.
Q. Do you have any problem if I refer to Allentown Women's Center in this deposition as AWC?
A. That sounds fine.
Q. As director, you are responsible for the overall operation of the clinic?
A. That's correct.

• • •

[11] Q. . . . . The items on this two page document Counselling Checklist are the items covered during an abortion counselling session; is that correct? Please, review it.
Q. Yes, this is accurate.

• • •

[16] Q. -- you said that pregnancy testing and counselling was available at AWC Monday through Saturday,with abortions being performed three to five days a week, depending upon patient needs?
A. Uh-huh.
Q. Is that information still correct?
A. Yes.
Q. And then it says, "An appointment usually can be

scheduled in approximately one week's time."
A. Yes.
Q. Is there any variation, does it ever take longer or shorter?
A. Yes.
Q. Do you ever know how long it takes?
A. Well, if we have more appointments than we have available slots, we attempt to add a day so we do not need to ask patients to wait.

Sometimes if we have more appointments than we have available slots, we get backed up and patients need to wait more than a week, depending upon physician availability, we either can or cannot solve that lag. If that is how it goes.

• • •

[46] Q. Exhibit "B" we discussed earlier and that is the counselling checklist, two page document.
[47] At the bottom of the page there is a section concerning minors and the first statement under that says, explain if complications develop their confidentiality may be broken. When or why would that occur?
A. If a patient requires a hospital transfer or a visit to a hospital, it might be that that care provider would not honor her confidentiality or it might be that the circumstances are such that her confidentiality is violated. For example, if a minor would have a gush of heavy bleeding, which sometimes happens even if there is no complication, and it were in the middle of the night, it might be very appropriate for her to involve her parents and the confidentiality might then be broken. We have no control over that.

We want our minors to understand as we provide the service to them, that their health and care is more important than their privacies around the abortion,

because that makes the overall experience safer for the minor if she has that frame of reference.

• • •

[49] Q. The fourth statement says, "If a parent is here, the parent must co-sign consent for abortion."
A. That's correct.

• • •

Q. Exhibit "C" is an eight page patient record; is that correct?
A. Yes.

• • •

[50] Q. And then in the middle of that are questions about pregnancy and history, live births, still births, miscarriages, abortions and complications of pregnancies; do you know why that information is gathered?
A. That information is gathered because it helps us both as we provide surgery to that patient and as we counsel that patient around her decision. The complications of pregnancy is largely important medically.

• • •

[51] Q. When I was reviewing the Interrogatories and I saw that a parent must sign the consent form;if a parent comes with a minor, is there a specific space on this on this paper where they sign or some separate form that they sign?
A. They sign where it says, "Witness." There is not a line that says,parent. There in not a provision in the form for a line that says parent at this time.

• • •

[58] Q. Is it correct, is the newspaper article correct in stating under the policy, if a woman -- I am sorry. The policy forces women who seek abortions, but say they think abortion should be illegal to delay the procedure?
A. That's correct.
Q. Could you explain this policy to me?
A. Yes. We do not have a set of questions that we ask patients about their views on whether or not abortion should be legel. There is no quiz or sequence of information seeking. However, some patients volunteer to us that they believe that abortion in wrong, is murder or should be illegal or [59] some combination of those attitude sets. Those patients who volunteer to us that abortion should be illegal and should not be available to women, we suggest to those patients that perhaps they should continue their pregnancy or consider that as a very serious option. And we consider that to be a red flag. That indicates that they might have difficulty with the decision later.

And that it is important that they process their decision making very carefully before they take the irreversible action of terminating their pregnancy, which sometimes women who are opposed to abortion want to quote "just get this over with." Those patients we suggest that they come back on another day and we explain to them all of their options.

And we further explain to them that they must take responsibility for their own decision making, that they cannot suggest that we as providers are responsible for the fact that they are having an abortion. And we ask them to sign a consent form that indicates that they have had full options counselling and that they take responsibility for their own decision making.
[60] And that it has a concluding paragraph that says

if they would ever allege that they had not been counselled properly when they had an abortion at the Allentown Women's Center and their options had not been fully explained to them, that we would indeed defend what we had done and open our records so that could be shown.

MS. MERSHIMER: Could I got a copy of this form?

MR. ZEMAITIS: We will take it under advisement.
BY MS. MERSHIMER:
Q. The newspaper article implied that a woman that would reflect that abortion was wrong, murder, illegal, either had to say she had changed her abortion belief or that she had signed this consent form; is the newspaper article summarizing that accurately?
A. No.
Q. If a woman who initially says that she feels abortion is wrong or illegal, and you advise her to think it over some more, and if she does and she returns to AWC, must she sign this additional form that you just said no matter what?
A. There are several points here you are addressing, [61] so I cannot answer your question as phrased.
Q. Why don't you explain the subtle points?
A. Approximately, fifteen per cent of our patients, we become aware that they think abortion is wrong. Those patients are not required to delay their procedure, except in certain instances. For instance, if they exhibit extreme ambivalence about the decision or if they are extremely distraught.

If in the best judgment of the counselor and the clinic supervisor, they had not adequately processed their decision making, we suggest to them that they take some time and come back another day.

Often they agree with us; infrequently, we turn them away.

Your question also included if a patient thinks abortion is illegal; if a patient thinks abortion is illegal, we share information with her about its legality, we give her accurate information. That slender number of patients who want to affirm the right to have an abortion, want to exercise the right to have an abortion without affirming it for other women who say, I believe abortion should not be legal. That patient, we say, [62] let's talk this over. And that patient, as of our new policy, we suggest that she come back another day for her procedure and process her own decision making and the difficulty we have with that position.

Our concern as a clinic is largely that we want it to be very clear for the record and to her, that all of her options have been explored and that this is a decision that she must take responsibility for. And that she must process before she makes an irreversible act.

Q. You said that this consent form, that such a woman must sign at the end has a paragraph about how if she ever says that she was not counselled properly,, that you will release the information publicly to the extent to defend it or maybe not to the extent, but to defend that you indeed counselled her?

A. Yes. If she says one, she had an abortion and two, it was at the Allentown Women's Center, and three, indicates in some way she did not have her options explained to her or was inadequately counselled or that in any way we were not non-directive or in some way coerced her into a rushed decision, we will then defend ourselves against those mistruths [63] by opening the record.

Q. The newspaper article, it said that two women were told to wait and they said that you had made that statement.

A. That's correct.

Q. Is it true that you had said since the policy was

started in April, that indeed two women were told to wait?

A. The first woman was in April. We had a staff meeting following her visit to our clinic. She indeed was asked to wait, but at that time the form had not been developed. It was developed as the result of her visit to our clinic. But functionally, she was asked to wait and went through the clarification of her options having been explained and so forth and so on, as we discussed in the form.

The form was then developed and then was used with the second patient, who came in, who volunteered to us that she felt that abortion should be illegal, but indeed that she did want one.

Q. The newspaper article said that both women came back, one saying she had dropped her opposition to legal abortion and the other signed a consent [64] form. The woman they are saying, dropped her opposition of legal abortion, is that the first woman in April?

A. Yes, yes.

Q. Is that accurate what the newspaper stated that she dropped her opposition to legal abortion?

A. It's accurate. she said that. I think it is also important that you have a complete picture, that had she not said that we still would have given her an abortion on the second visit, if it was clear to us that that is what she wanted.

Q. Do you know how long a period of time was between her first visit to AWC and her second visit when she had the abortion?

A. No, but it was short.

Q. Less than a week, more than a week, do you know?

A. That is retrievable. I don't even know if that is retrievable at this point. It was short. It was probably not more than a week, but I can't guarantee it. I could say with pretty well absolute certainty that it was two

weeks.
Q. With the second woman who signed the consent form, do you know the period of time between when [65] she first came to AWC and when she returned and signed the consent form?
A. The same, it was short.
Q. With the same, probably under a week, but definitely under two weeks.

You had said early on, and correct me if I am wrong, that women who say they believe abortion is wrong or murder or illegal, that raises a red flag to AWC that they might have some trouble or some ambiguity or uncertainty with the abortion decision; is that fair?
A. It raises a red flag about more than that. It raises a red flag about that they might possibly have more guilt or more damaged self-worth or some kind of adverse psychological sequelae is more likely in those instances. So all of those things are taken, you know, addressed by the counselor in her thinking process.

* * *

[66] Q. Who has to sign the consent form?
A. Let's take this very slow. If approximately fifteen per cent of our patients we become aware without asking that they believe in some way that abortion is wrong or murder or something to that effect, but still wish to have one. Less than one per cent of our patients volunteer to us that they believe that abortion should not be available to other women, it should be illegal, which is stronger and more extreme. But that they would like to exercise the option of having a legal abortion and they would also like to cutoff that option for other women.

Those women in the fifteen per cent category, sometimes we ask patients to wait, because they are so ambivalent or so distraught as they present themselves to

us that we want to give them or sometimes they are coerced. Those women we want to give the opportunity to further process their decision making before they take an irreversible act. That is for the best interest of the patient.

That slender number of patients [67] who say that abortion should be illegal, not only for their sake, but also because we want to share with them that we need to make it clear that they must take responsibility for their own decision making and not lay it at the feet of the provider, that we are going to ask them to delay their abortion and return on another day after they have fully processed that they have explored their options and that they understand that they must take responsibility for their decision making.

MR. ZEMAITIS: Let me just ask a question, which I think will help clear it up.

The fifteen per cent, the larger group of women,are all of those women required to sign this new form?

THE WITNESS: None of them. This form has only been used twice and we see over four thousand patients a year.

MR. ZEMAITIS: The only time the form is used is in that much smaller group of people, where the woman thinks that abortion should be illegal and she returns on a second visit; is that right?
[68] THE WITNESS: She then returns on a second visit and she then -- to date, all of these women have remained steadfast in their desire to terminate their pregnancy.

There may be many more women who come to our clinic who think that abortion should be illegal, but we do not ask questions about that.
BY MS. MERSHIMER:
Q. So it is this one per cent or even smaller group --
MR ZEMAITIS: Much smaller.

BY MS. MERSHIMER:
Q. -- that feel abortion should not be available for all women that are asked to sign a consent form?
A. Correct.
Q. Or what is this form called, because I do not want to call it a consent form?
A. It's so new, it doesn't have a name.

I would just like to say that there is an error in this article. We never say, you may return if you change your mind. We do not attempt [69] to change people's minds.

• • •

[70] Q. For the record, we have had marked as Defendant's Exhibit-21 the form that we have been discussing for the last few minutes; that has no caption to it, correct?
A. Yes.
Q. You had said that one woman had returned to the clinic;that second women, and she had signed this form?
A. Yes.
Q. If she had not signed the form,had refused to sign the form, could she have received an abortion at AWC?
A. I think not. But I think the form functions largely as an information sharing and educational device. So I think it's extremely unlikely that such a situation would arise.
Q. In the last paragraph --

MR. ZEMAITIS: You have not had to face that situation yet?

THE WITNESS: That's correct.

BY MS. MERSHIMER:
In the last paragraph, one of the statements [71] is that, "If in the future I --"
A. There should be an "If."
Q. "If in the future I ever publicly state that the

Allentown Women's Center counselled me inadequately or that I was not fully aware of the gravity of what I was doing in terminating my pregnancy, I understand that I will by so doing, give up all right to confidentiality and that the staff of the Allentown Women's Center will defend their non-directive counselling protocols publicly."

My question to you is: What is meant by "all right to confidentiality?"
A. We are affirming our right to confirm that this patient who has already said that she had an abortion at the Allentown Women's Center, to give our version of that event and to represent it accurately, specifically the counselling component.
Q. So you would not release her entire patient record then?
A. No, we would not do that and that is not made clear or unclear by this statement. But we would not, in fact, consider that to be relevant. We would only correct any misinformation that she might be giving out about our facility.

• • •

Defendants' Exhibit 60:
Discovery Excerpts

PLAINTIFF'S OBJECTIONS AND RESPONSES TO DEFENDANTS' REQUESTS FOR ADMISSIONS

Plaintiffs respond to Defendants' Requests for Admissions as follows:

* * *

Request for Admission No. 2:

While delay in the performance of an abortion may increase the risks to the patient from both a mortality and a morbidity standpoint, the increased risks may be negligible and are dependent upon the stage of gestation (first, second, or third trimester). A week delay in the first trimester will not likely result in a harm while there may be greater risks in the second trimester, with the risks more worthy of consideration in the latter part of the second trimester and throughout the third trimester.

Response to Request for Admission No. 2:

Request for Admission No. 2 is **admitted**.

* * *

Request for Admission No. 8:

Some early abortions may be more dangerous than later abortions due to the condition of the patient, the type of procedure used in performing the abortion, or the skill of the performing physicians.

Response to Request for Admission No. 8:

Request for Admission No. 8 is **admitted**.

* * *

DEFENDANTS' RESPONSES TO PLAINTIFFS' REQUESTS FOR ADMISSION AND INTERROGATORIES ADDRESSED TO DEFENDANTS

* * *

Request for Admission No. 10

Adolescents have one of the highest suicide rates of any segment of the population.

RESPONSE:

Defendants object to this interrogatory as being irrelevant to the constitutionality of the Act, particularly in that this admission does not distinguish between males and females and in that it does not relate to pregnant teens. Without waiving this objection, Admission No. 10 is **DENIED**.

ANSWER TO INTERROGATORY NO. 10:

The attached two tables (Exhibits 2 and 3) demonstrate that in Pennsylvania and the United States, teenagers have the lowest rate of suicide among the age groups.

* * *

Commonwealth of Pennsylvania - Department of Health
State Health Data Center

Resident Suicide Deaths by Age and Sex,
Number and Rate, Pennsylvania, 1987 (Provisional)

BY NUMBER:

AGE GROUP	TOTAL	MALES	FEMALES
All Ages	1,489	1,210	279
Under 10	0	0	0
10-14	14	12	2
15-19	89	72	17
20-24	145	127	18
25-34	319	269	50
35-44	219	173	46
45-54	180	129	51
55-64	178	131	47
65-74	194	165	29
75+	151	132	19

BY RATE:*

AGE GROUP	TOTAL	MALES	FEMALES
All Ages	12.5	21.3	4.5
Under 10	-	-	-
10-14	1.8	3.0	0.5
15-19	9.8	15.6	3.8
20-24	14.8	25.8	3.7
25-34	16.4	27.9	5.1
35-44	14.1	22.9	5.8
45-54	15.4	23.2	8.3
55-64	14.2	22.6	6.9
65-74	19.7	39.6	5.1
75+	20.6	51.3	4.0

* Rate per 100,000 estimated 1986 population for each specified age group.

• • •

EXCERPTS FROM PLAINTIFFS' TRIAL EXHIBITS

Plaintiffs' Exhibit 49:
DOH Instructions and Definitions
for Report of Induced
Termination of Pregnancy Form
(July 1988)

INSTRUCTIONS AND DEFINITIONS
REPORT OF INDUCED TERMINATION
OF PREGNANCY

Pennsylvania
Department of Health
State Health Data Center
July, 1988

INTRODUCTION

Purpose: These instructions and definitions are designed as an aid to acquaint hospital and clinic personnel, physicians, and others with responsibilities related to completing and filing reports of induced termination of pregnancy (induced abortion), The purpose is to achieve improved reporting by promoting better understanding of the forms and of the uses of information entered on them.

Generally the person in charge of the institution or facility where the induced abortion is performed has the overall responsibility for obtaining the required data, preparing the report, and filing the report with the Department of Health. For abortions performed outside a hospital, clinic, or other institution, the physician performing the abortion is responsible for preparing and filing the report.

State Reporting Requirements: The reports shall be completed by the hospital or other licensed facility, signed by the physician who performed the abortion and transmitted to the Department of Health within 15 days after each reporting month. Mail to the

Department of Health
State Health Data Center
ISSR Unit
P. 0. Box 90
Harrisburg, PA 17108

Specific Responsibilities: The hospital, clinic or other institution or facility where the induced abortion is performed is responsible for obtaining the necessary data, completing the form, and filing it with the State within the time period specified by law. To ensure the proper performance of these responsibilities, it is preferable that one staff member be given the overall responsibility and authority to see that the reports are completed and filed on time. Specifically, the hospital, clinic, or other institution should:

- o Develop efficient procedures for prompt preparation and filing of reports.
- o Collect and record the information required by the report.
- o Prepare a correct and legible report, making certain that every item is completed.
- o File the report within the time specified in the Abortion Control Act (15 days after each reporting month).

- o Cooperate with State officials concerning queries on report entries.

- o Call on the State Health Data Center at (717) 783-2548 for advice and assistance when necessary.

Physician: For induced abortions performed in a hospital, clinic, or other institution, the physician performing the abortion is responsible for providing the medical information required by the report. When an induced abortion is performed outside a hospital, clinic, or other institution, the physician performing the abortion is responsible for obtaining all of the necessary data, completing the form, and filing it with the State within the time period specified by law.

PART I - GENERAL INSTRUCTIONS FOR COMPLETING REPORTS

The data necessary for preparation of the induced termination of pregnancy report are obtained from the:

- o Patient

- o Attending physician

- o Hospital or clinic records

The data obtained from these reports are very important from both a demographic and a public health viewpoint. Therefore, it is essential that these reports be prepared accurately. These general rules should be followed:

- o File the *original* report with the Department of Health. These reports have sequential file numbers. *Do not reproduce or duplicate these forms.*

- o Avoid abbreviations except those recommended in the specific item instruction.

- o Spell entries correctly.

- o Refer problems not covered in these instructions to the State Health Data Center.

- o Use the current form designated by the State.

- o Type all entries whenever possible. Do not use worn typewriter ribbons.

- o If a typewriter cannot be used, print legibly in black ink.

- o Complete each item following the specific instructions for that item.

PART II -- COMBATING THE REPORT OF INDUCED TERMINATION OF PREGNANCY

These instructions pertain to the 1988 Report of Induced Termination of Pregnancy.

1-2 PLACE OF TERMINATION

1. FACILITY NAME

Enter the full name of the hospital or clinic where the induced termination of pregnancy occurred.

If the induced termination of pregnancy occurred in a hospital or a clinic that is physically situated within a hospital or is administratively a part of a hospital, enter the full name of the hospital.

If the induced termination of pregnancy occurred in a freestanding clinic, a clinic that is physically and administratively separate from a hospital, enter the full name of the clinic.

If the induced termination of pregnancy occurred in a physician's office or some other place, enter the name of the office or place.

In the coding boxes, enter the five-digit number found on the first line of your mailing label, as shown below.

8-0228
WOMENS HEALTH SERVICES
107 SIXTH STREET
FULTON BUILDING 3RD FLOOR
PITTSBURGH, PA 15222

ATTN: PATRICIA MADDEN

2. COUNTY OF PREGNANCY TERMINATION

Enter the name of the county where the pregnancy termination occurred. In the coding boxes, enter the correct county code. See Appendix A.

3. PATIENT'S IDENTIFICATION

Enter the hospital, clinic, or other patient identification number. This number must be one that would enable the facility or physician to access the medical file of this patient. Do not use the patient's name.

4 a-b. RESIDENCE OF PATIENT

The patient's residence is the place where her household is located. This is not necessarily the same as her "home State." "voting residence," "mailing address," or "legal residence." The State and county should be that of the place where the patient actually lives. Never enter a temporary residence such an one used during a visit, business trip, or a vacation. Residence for a short time at the home of a relative or friend is considered to be temporary and should not be entered here. Place of residence during a tour Of military duty or during attendance at college is not considered temporary and should be entered an the place of residence of the patient on the report.

If the patient has been living in a facility where an individual usually resides for a long period of time, such as a group home, mental institution, nursing home, penitentiary, or hospital for the chronically ill, this facility should be entered as the place of residence.

4 a. RESIDENCE - STATE

Enter the name of the State where the patient lives. This may differ from the State in her mailing address. If the patient is not a resident of the United States, enter the name of the country and the name of the unit of government that is the nearest equivalent of a State.

4 b. RESIDENCE - COUNTY

Enter the name of the county where the patient lives.

In the coding boxes, enter the correct county code. See Appendix A. For counties outside Pennsylvania, leave

blank.

5. DATE OF PREGNANCY TERMINATION

Enter the exact month, day, and year of the pregnancy termination.

The date the pregnancy was actually terminated should be entered. This may not necessarily be the date the procedure was begun.

Enter the full name of the month - January, February, March, etc. Do not use a number or abbreviation to designate the month.

6. AGE LAST BIRTHDAY

Enter the age of the patient in years at her last birthday.

7. CLINICAL ESTIMATE OF GESTATION

Enter the length of gestation as estimated by the attending physician in completed menstrual weeks. Do not compute this information from the date last normal manses began and date of termination. If the attendant has not done a clinical estimate of gestation, enter "None."

8. PREVIOUS PREGNANCIES (complete each section)

8 a. Now Living

Enter the number of children born alive to this patient who are still living at the time of this termination. Do not include children by adoption. Check "None" if the

patient has had no previous pregnancies, or if all previous children are dead.

8 b. Now Dead

Enter the number of children born alive to this patient who are no longer living at the time of this termination. Do not include children by adoption. Check "None" if the patient has had no previous pregnancies or if all previous children are still living.

8 c. Spontaneous

Enter the number of previous pregnancies that ended spontaneously and did not result in a live born infant. This should not include induced terminations. Check "None" if the patient has had no previous pregnancies or if all previous pregnancies ended in live born infants.

8 d. Induced

Enter the number of previous induced terminations (induced abortions) that this patient has had. Do not include this termination. Check "None" if the patient has had no previous induced terminations.

9 a-b. TYPE OF TERMINATION PROCEDURES

(Definitions of certain abortion procedures can be found in Appendix B)

9 a. Check the box that describes the primary procedure that actually terminated this pregnancy. Check only one box. If more than one procedure was used, identify the additional procedure(s) in item 9b. If a procedure not listed was used, check "Other" and

specify on the line provided.

9 b. Check the box(es) that describe the additional procedure(s) used. If no additional procedures were used, leave all boxes blank. If a procedure not listed was used, check "Other" and specify on the line provided.

10. MEDICAL COMPLICATIONS OF PREGNANCY

Check all that apply. If none apply, leave item blank.

11. NAME OF ATTENDING PHYSICIAN

Enter the full name of the attending physician. Be sure to spell it correctly and verify correct spelling. This item is used to query for missing or additional information.

Complete the license number of the physician, the signature, and the date submitted to the Department of Health.

APPENDIX A
PENNSYLVANIA COUNTY CODES

COUNTY CODE	COUNTY	COUNTY CODE	COUNTY
01	Adams	35	Lackawanna
02	Allegheny	36	Lancaster
03	Armstrong	37	Lawrence
04	Beaver	38	Lebanon
05	Bedford	39	Lehigh
06	Berks	40	Luzerne
07	Blair	41	Lycoming
08	Bradford	42	McKean
09	Bucks	43	Mercer
10	Butler	44	Mifflin
11	Cambria	45	Monroe
12	Cameron	46	Montgomery
13	Carbon	47	Montour
14	Centre	48	Northampton
15	Chester	49	Northumberland
16	Clarion	50	Perry
17	Clearfield	51	Philadelphia
18	Clinton	52	Pike
19	Columbia	53	Potter
20	Crawford	54	Schuylkill
21	Cumberland	55	Snyder
22	Dauphin	56	Somerset
23	Delaware	57	Sullivan
24	Elk	58	Susquehanna
25	Erie	59	Tioga
26	Fayette	60	Union
27	Forest	61	Venango
28	Franklin	62	Warren

29	Fulton	63	Washington
30	Greene	64	Wayne
31	Huntingdon	65	Westmoreland
32	Indiana	66	Wyoming
33	Jefferson	67	York
34	Juniata		

APPENDIX B
DEFINITIONS OF INDUCED ABORTION PROCEDURES

Suction curettage (Also known an vacuum aspiration). - In this procedure the cervical canal is dilated by the successive insertion of instruments of increasing diameter called dilators. When the opening is large enough, a flexible tube (cannula) is inserted into the uterine cavity, and the fetal and placental tissues are then suctioned out by an electric vacuum pump.

Sharp curettage (Also known as dilatation and curettage, D & C, or surgical curettage). - This procedure involves the dilation of the cervix an in suction, although usually to a larger diameter. The fetal and placental tissues are then scraped out with a curette, which resembles a small spoon.

Dilation and evacuation (D & E). - This procedure, used most frequently in the second trimester, involves opening the cervix (dilation) and using primarily sharp techniques, but also suction and other instrumentation such an forceps for evacuation.

Intrauterine saline instillation (Also known as saline abortion and saline amniotic fluid exchange). - This procedure entails withdrawing a portion of the amniotic fluid from the uterine cavity by a needle inserted through the abdominal wall and replacing this fluid with a concentrated malt solution. This process induces labor, which results in the expulsion of the usually dead fetus approximately 24 to 48 hours later.

Intrauterine prostaglandin instillation. - This procedure involves injecting a prostaglandin - a substance with

hormonelike activity - into the uterine cavity through a needle inserted through the abdominal wall. The interval between injection and expulsion tends to be shorter than in a saline abortion.

Hysterotomy. - This procedure involves surgical entry into the uterus, as in a cesarean section, that removes a fetus that is too small to survive even with extraordinary life support measures. It is usually performed only if other abortion procedures fail.

Hysterectomy. - In this procedure, the uterus is removed either with the fetus inside or after the fetus has been removed. It is usually performed only when a pathological condition of the uterus, such as fibroid tumors, warrants its removal or when a woman desires sterilization.

All definitions, except for D & E, are from *Legalized Abortion and the Public Health* (Institute of Medicine, 1975). The definition of D & E is based on national Center for Health Statistics consultation with the Center for Health Promotion and Education, Centers for Disease Control.

All other procedures should be shown an "Other" and the specific procedure listed. This category includes procedures using a combination of agents, such as urea and prostaglandin, prostaglandin and oxytocin, or prostaglandin and saline.

APPENDIX C
DEFINITIONS

The following definitions are included in the 1977 revision of the Model State Vital Statistics Act and Regulations. The definitions of live birth and fetal death conform to the definitions adopted by the Assembly of the World Health Organization.

Live birth is the complete expulsion or extraction from its mother of a product of human conception, irrespective of the duration of pregnancy, which after such expulsion or extraction, breathes, or shows any other evidence of life such an beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles, whether or not the umbilical cord has been cut or the placenta is attached.

Note - If an infant breathes or shows any other evidence of life after complete delivery, even though it may be only momentary, the birth must be registered as a live birth and a death certificate must also be filed.

Fetal death is death prior to the complete expulsion or extraction from its mother of a product of human conception, irrespective of the duration of pregnancy; the death is indicated by the fact that after such expulsion or extraction, the fetus does not breathe or show any other evidence of life, such as beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles.

Induced termination of pregnancy is the purposeful interruption of pregnancy with the, intention other than to produce a live-born infant or to remove a dead fetus and which does not result in a live birth.

Note - If an induced termination is performed on a fetus of 16 weeks gestation or longer, a Certificate of Fetal Death as well as a Report of Induced Termination of Pregnancy must be filed.

REPORT OF INDUCED TERMINATION OF PREGNANCY MONTHLY TRANSMITTAL FORM

Please return this page with all of your completed Report of Induced Termination of Pregnancy forms for the reporting period of AUGUST 25-31 by September 15, 1988. Also, complete the requested information below for your facility:

FACILITY I.D. __-__ __ __ __ __

NAME OF FACILITY _____

CONTACT PERSON/TITLE _____

TELEPHONE NUMBER ( ) ____ - _____

DATE SUBMITTED _____

NUMBER OF COMPLETED FORMS ENCLOSED ____

Please complete and return this page even if you do not have any procedures to report.

MAIL TO: Pennsylvania Department of Health
State Health Data Center
ISSR Unit
PO Box 90
Harrisburg, PA 17108

Plaintiffs' Exhibit 60:
Veto Message to the Pennsylvania Senate
on S.B. 742
of Governor Dick Thornburgh
(Dec. 23, 1981)

December 23, 1981

To the Honorable, the Senate
of the Commonwealth of Pennsylvania

I have before me for action Senate Bill 742, Printer's No. 1535, which would establish a number of detailed procedures and requirements with respect to the performance of medical abortions.

Perhaps no issue in recent times has generated more concern, conflict and passion than the issue of what, if any, restrictions should be imposed upon the ability to obtain an abortion. Perhaps, then, it should not be surprising that this bill has led to a considerable amount of public passion and controversy. Unfortunately, it also appears to have generated a considerable amount of misinformation and misunderstanding.

Many who favor stringent limitations on abortion appear to perceive this bill as a means of furthering that objective. Many who oppose most or all restrictions on abortion appear to perceive this bill as preventing virtually all abortions.

I have carefully studied this bill and those opinions of the United States Supreme Court and other federal courts which establish the legal and constitutional parameters for the performance of medical abortions. I also have reviewed similar laws in other states and a variety of relevant materials and opinions reflecting all

points of view on the cluster of issues related to the abortion question.

I have concluded that this bill does far less to restrict the ability of a woman to elect to have an abortion than its proponents perceive or its opponents fear.

I have stated a number of times in the past my personal opposition to abortion on demand, and my view that abortion should not be employed as an alternative to birth control techniques. I have also expressed my concern that too many abortions are too casually undertaken. This is a matter of particular concern with regard to teen-agers who are usually less equipped than adults to independently evaluate the decision to have an abortion or understand the consequences it may later entail.

On the other hand, I also have stated in the past my personal view that abortion should be a permissable medical option in certain narrowly restricted situations, including threat to the life of the mother, rape, incest or serious and irreparable harm to the health of the mother.

While this bill contains a number of proposed requirements with which I am in agreement, I have concluded that it really does little, if anything, to prohibit abortions which can now be performed in the Commonwealth.

What this bill would do is erect a series of hurdles which would have to be cleared by a pregnant woman interested in obtaining an abortion.

Any competent, pregnant, adult intent upon obtaining an abortion who could negotiate those hurdles, could obtain one, much as she now could in this state. It must be assumed that the same services now available to assist and counsel women considering abortion would be available to provide assistance to any such woman in negotiating the procedural hurdles contained in this bill.

On the other hand, for those women, often minors,

who face the dilemma of an unwanted pregnancy with fear or ignorance, some of these proposed procedures would provide certain valuable information and protection.

Specifically, the bill would permit a pregnant woman to elect an abortion before the fetus is viable -- that is, capable of surviving outside the body of the mother -- if her physician made a medical determination that it was necessary in light of all factors relevant to the well-being of the woman, including physical, emotional, psychological, age and family circumstances.

The bill would, however, require women seeking such abortions to be counselled on the options with regard to an unwanted pregnancy and the consequences of each, including the medical risks involved in both proceeding with an abortion and with carrying the fetus to term. It would then require a waiting period of one day, which would provide the woman with an opportunity to assess and reflect upon this information. This waiting period would not apply where a medical emergency compelled the performance of an abortion.

The bill would require minors and adjudged incompetents to obtain the consent of a parent or guardian for an abortion if so desired. In the alternative, such a pregnant woman could obtain a court order authorizing the performance of an abortion upon a finding either that the woman is mature and capable of giving her informed consent, or that the performance of an abortion would be in the woman's best interests. In such a proceeding, the pregnant woman would be entitled to court-appointed counsel, and all proceedings would be confidential. In assessing the best interests of a minor seeking an abortion, I must assume that any court would rely heavily on the best medical judgment of the petitioner's physician.

The bill would require that any abortion after the

first trimester of pregnancy be performed in a hospital.

The bill would require certain precautions to help insure the survival of an aborted fetus which was viable. Where a physician has determined prior to an abortion that the fetus is, in fact, viable, an abortion could only be performed upon a determination by the woman's physician that the abortion was necessary to preserve her life or health, and then, to the extent medically feasible, by the method most likely to preserve the viability of the fetus. I am advised that this is already the case pursuant to current normal medical practice.

The bill would require that physicians performing abortions file reports setting forth certain detailed information relating to the facts and circumstances involved in the abortion. Such records would not contain the identity of the pregnant woman, but would be available for public inspection.

The bill would place restrictions an abortion-related coverage that could be provided in health care and disability insurance policies.

The bill provides for an annual review by the state Health Advisory Board of the standards and criteria for assessing viability, While the specific question of viability in any particular case appears to be left to the medical determination of the attending physician, the regularly revised standards devised by this board would appear to constitute a presumption against which each physician's determination could be judged. I have reservations about this provision. It has the potential to further politicize and complicate the whole issue of abortion. It will focus undue attention on a small board that may not reflect the consensus in the medical community at any given time on an issue that seems best left to the unfettered determination of individual treating physicians on a case-by-case basis. This is particularly troublesome since, by law, only half of that board's members are

physicians. I do not object to a periodic review and revision of criteria of viability. I believe, however, that this should be the responsibility of the recognized organizations of the medical community -- not of government.

Finally, this bill defines human life as beginning at the moment of fertilization. Much of the intent and purpose of the bill appears to flow from that assertion.

I do not believe that I have the scientific or theological expertise to affirm or refute that premise, nor do I believe that the members of the General Assembly do. The U.S. Supreme Court has noted the consensus among medical practitioners and theologians over a long period of time that human life does not begin until the time of viability or even later. The court has noted that this has been the predominant view in the Jewish and Protestant communities, and was also "official Roman Catholic dogma" until the last century.

It has been argued by many that the extremely detailed nature of some of the counselling and reporting requirements, when combined with the stringent criminal penalties that are provided for virtually any violation, is intended to deter women from seeking abortions and physicians from performing them, even under circumstances where the courts have made clear that abortions cannot be constitutionally restricted. I believe that these provisions, combined with the "human life" definition and power of a small state board to set standards of viability, have given rise to most of the concern and consternation expressed over this bill.

In performing my responsibility to properly evaluate this bill, I must carefully weigh not only the literal substance of the bill but what its effects could be. There is no bill to which I have given more careful consideration or undertaken more precise review and reflection. I have reached the following conclusions.

The medical necessity test for obtaining an abortion prior to the viability of a fetus, is consistent with U.S. Supreme Court holdings and is, in my view, reasonable.

The requirement for counselling and assessment are, in my view, reasonable for someone confronting a surgical procedure of this type and a personal decision of this magnitude -- one which studies show could have lasting emotional impact. Requiring a physician to provide such counselling or medical advice is, in my view, reasonable and comparable to the kinds of things physicians do in other similar situations. Indeed, I would think that any thoughtful and sensitive physician, under any circumstances, would agree that it is appropriate to apprise a patient of the various potential medical, psychological and other risks and effects associated with such a procedure. Further, I think it is right to explain to a pregnant woman that there are alternatives to abortion if her only objection is raising the child or her only fear is the inability to support the child. An abortion that would not be performed but for ignorance or fear is perhaps an abortion best not performed.

On the other hand, I doubt that requiring the preparation and availability of detailed color photographs of a fetus at various gestational increments is necessary to an informed abortion decision. Moreover, their presentation would likely cause many women considerable anguish and distress.

While I personally believe that a brief, so-called "waiting period" is reasonable, I must note that comparable provisions in other bills have been held unconstitutional by a number of federal appeals courts.

I feel that the provision for parental or guardian consent, or in the alternative, court review, is reasonable and consistent with traditional and legal parental responsibilities for the welfare of their minor children, and with the traditional role of the courts to determine,

when necessary, the best interests of minor children. At no time is a minor more likely to need or stand to benefit from the guidance and support of a responsible adult than when facing the emotional trauma and dilemma of an unwanted pregnancy. I believe, however, that if the alternative of a court determination is to meet constitutional standards of reasonableness, it should include a specific, limited time period within which the court must act rather than the more general and undefined term, "promptly", as the bill now provides.

I do not believe that the requirement that an abortion on a woman beyond the first trimester of pregnancy be performed in a hospital is unreasonable. In fact, the great majority of abortions are performed in the first trimester. Abortions performed beyond that period are more likely to entail greater risks, complications and care. However, I have serious reservations about the proposed requirement that all such abortions be performed on an in-patient basis. The necessity of proceeding on an in-patient basis, in my view, should be determined on a case-by-case basis by the attending physician. Clearly, proceeding on an in-patient basis would involve a greater burden and cost to the woman involved. Where the need to proceed on an in-patient basis is not reasonably related to maternal health or the protection of a potentially viable fetus, this requirement would appear to be unduly restrictive and thus unconstitutional.

The provisions which limit the aborting of a fetus medically determined to be viable and which require precautions to preserve the life of an aborted fetus which is in fact viable are, in my view, right and reasonable. In fact, the overwhelming majority of abortions are performed before any question of viability arises. I cannot disregard a recent *Philadelphia Inquirer* investigative feature which exposed the fact that in at

least some cases of more advanced pregnancy, viable fetuses were being aborted and permitted to die. If a fetus is capable of living and growing outside the womb, it is difficult for me to accept that it does not embody a human life. If we are to regard ourselves as a humanitarian society, I believe that we must take every reasonable precaution in favor of the preservation of innocent life. This would include, in my view, requirements such as the ones in this bill for the presence of a second physician where an aborted fetus may be viable and utilization of the abortion technique, where consistent with maternal life and health, most likely to preserve a viable fetus.

I am troubled, however, by the provision in Section 3212 (B) of the bill which, when read in conjunction with the definitions of "born alive" and "viability" in Section 3208, would appear to require the use of every scientifically possible means, including artificial sustenance, to maintain in a technical state of life, presumably indefinitely, an aborted fetus or organism, however defective, deficient, or diseased, that does not embody any prospect of human life as we know it. While this may not have been the intent of the legislation, this provision could require a physician, under the risk of severe criminal penalties, to artificially maintain even an aborted anencephalic fetus, that is, one with no head or brain. Such cases have been documented.

The provision would establish a higher standard of care for a viable fetus or human organism than is required in the case of a diseased or failing adult. Whether and when artificial means of sustenance should be employed is a decision which, in my view, is best left to the affected family and their physician.

I believe that some general reporting requirements are reasonable and could provide the kind of data that

would be beneficial in enabling us to make more informed judgments about the continuing questions related to the matter of abortion. Indeed, 30 other states have enacted legislation with some type of reporting requirements. However, I have reservations about several of the specific reporting requirements proposed in this bill, and a particular concern about the availability of such reports for general public inspection. I am concerned that this could lead to the compromising of the identities and privacy of women who have obtained abortions, and of the doctor-patient relationship.

I also have some reservations about the constitutionality of some of the restrictions in the insurance provision and on the use of public health facilities in performing abortions. Where the latter are the only accessible facilities for women who are seeking abortions under circumstances where they would be permitted in private facilities, the application of this restriction seems unfair and has been held unconstitutional.

I have reviewed the history and development of this bill. it appears to me that the various amendments and revisions to the bill as initially proposed reflect a genuine effort to adopt procedures to insure informed consent by adults and reasonable protection for the well-being of minors considering abortion, as well as standards and procedures for protecting and preserving, to the extent possible and consistent with the life and health of the mother, the potential for new human life, and to do so within the constitutional limitations prescribed by the U.S. Supreme Court.

The U.S. Supreme Court has recognized the interest of a state in reasonably regulating abortion in ways related to maternal health and well-being, and for the purpose of protecting the "potentiality of human life." I believe that many provisions of the bill, as I have

indicated, are consistent with those interests and are reasonable, particularly with regard to those women who, because of their circumstances, would benefit from the guidance and protection afforded by them.

On the other hand, I am concerned that other provisions, and to some extent, the overall tone and tenor of the bill, would have the effect of imposing an undue and, in some cases, unconstitutional burden upon even informed, mature adults intent upon obtaining an abortion under circumstances in which the U.S. Supreme Court has determined they are entitled to do so. For example, Section 3213 would preclude the victim of a rape who has made an informed and mature decision that she absolutely does not want to bear any child that might result from that rape from exercising the option of menstrual extraction, and would force her to wait the five weeks or more that is required for the fact of pregnancy to be determined. This requirement would appear to needlessly subject a woman in such a stressful situation to additional trauma.

Likewise, I am concerned that some of the detailed, complex, and burdensome requirements of the bill, accompanied as they are by severe criminal penalties, could well foster an atmosphere in which many physicians would be deterred from providing the kind of abortion-related medical services to which the U.S. Supreme Court has held their patients are constitutionally entitled. This could well disrupt the traditional doctor-patient relationship and impinge upon the right of physicians to practice. Of even greater concern is the potential for more experienced and conscientious physicians to refrain from involvement in even medically necessary abortions, and to abandon the field to marginal practitioners. It could even lead to a resurgence of "back alley" abortions, which no thoughtful person would wish to happen. I believe that this concern

could be alleviated by reduced criminal sanctions which would still be sufficient to deter physicians from willful violations.

I am also concerned that in its entirety the bill in its current form goes further than is necessary in protecting the state interests in this area to which I have referred. In so doing, it threatens to create additional regulation and bureaucracy and to unduly involve government in the private lives of its citizens.

Accordingly, and after extensive consideration and deliberation, I am returning this bill without my signature. In so doing, I wish to indicate the availability of my office to work with the General Assembly in developing revised legislation to effectuate the provisions with which I have indicated my agreement consistent with the objections I have expressed.

/s/_____
Dick Thornburgh
Governor

Plaintiffs' Exhibit 61:
Message to Pennsylvania Senate on Signing of 1982 Pennsylvania Abortion Control Act of Governor Dick Thornburgh (June 11, 1982)

June 11, 1982

To the Honorable, the Senate
of the Commonwealth of Pennsylvania

I have before me for consideration Senate Bill 439, Printer's No. 2049, which would require the Commonwealth to provide to criminal justice agencies certain criminal record information, upon appropriate request, free of charge. This bill has been subject to a number of unrelated amendments, the most important, and only controversial, one of which has to do with the procedures related to the performance of abortions in the Commonwealth.

I was confronted with such a measure in the form of S.B. 742 last December. That bill contained 11 provisions to which I objected. In addition, the overall tone and tenor was such that I felt it could have a chilling effect in a constitutionally-protected area, and created an aura of undue government intrusion into private lives which conflicted with my convictions and philosophy. On Dec. 23, 1981, I vetoed that bill, setting forth in detail those concerns and objections.

My careful review of this revised measure reveals that the statement of the bill's sponsor that the new measure was "tailored" to meet my objections appears to be accurate. My review reveals that virtually every item in the initial bill to which I objected has been removed or appropriately revised in the current measure.

Key among the 11 provisions to which I objected in

the original bill were:

•A definition of "human life" as commencing at the instant of fertilization. I objected to this, and it has been removed from the current bill.

•A requirement that the state Health Advisory Board set standards of fetus viability and, moreover, review and revise such standards on an annual basis. I objected to this and expressed the view that the question of viability was more properly determined on a case-by-case basis by an attending physician. This provision has been removed from the current bill.

•A provision requiring that detailed color photographs depicting the incremental development of the human fetus in the womb be made available for showing to women contemplating abortion. I objected to this and expressed the view that if imposed an unreasonable and potentially anguishing burden on women contemplating abortion. This provision has been removed from the current bill.

•A requirement that all abortions after the first trimester be performed on an in-patient basis. I felt that this was a matter better left to the judgment of the woman involved and her treating physician. I objected to this provision, and it has been removed from the current bill.

•A prohibition of menstrual extraction, even in cases of rape. I found this objectionable. This has now been eliminated in the bill currently before me.

•A provision prohibiting the inclusion of abortion coverage in standard medical insurance policies issued in the Commonwealth. I objected, and this provision has been removed from the current bill.

•Provisions which would have required the use of heroic efforts and artificial sustenance to maintain

in a technical state of survival any fetus once aborted which was capable of being so maintained, however deformed and regardless of its prospects for any meaningful life as we know it. This would even have included anancephalic fetuses (i.e., those literally born without a head or brain). I objected to this. It has been eliminated in the current bill before me. Under the current bill, physicians would only be required to provide the same types of treatment to an infant aborted alive that they would to a live adult under comparable circumstances. This is totally consistent with existing medical standards and legal obligations.

•Certain reporting requirements relative to the performance of abortions which in my view did not adequately protect the confidentiality of the doctor-patient relationship and the right of personal privacy. I objected, and the relevant provisions have been eliminated in the current measure.

•A provision effectively preventing the performance of abortions in state-owned or operated hospitals. I objected to this, and expressed the view that it would discriminate against women seeking abortions who did not have access to private hospitals. This provision has been eliminated. The new bill would permit abortions to be performed in state-owned or operated hospitals unless there was another nearby hospital in which such an abortion could be performed.

Severe criminal penalties on doctors who violated even the ministerial provisions of the act. I objected to this. The penalty structure has been drastically altered in the current bill. In certain cases, criminal sanctions have been removed altogether. In the other instances, the criminal sanctions imposed are now consistent with penalties

that already exist for comparable conduct and in laws similar to this one as enacted in many other states.

*A provision for court review of requests by a juvenile for an abortion that failed to impose any time limit within which the court must act, and thus created the prospect of an indefinite and unappealable delay in the process. I objected to this omission, and the current bill would now impose a requirement for speedy action in such court proceedings.

This bill does contain eight provisions concerning abortion procedures which were contained in the original bill presented to me. At the time I vetoed that bill, I stated that I did not approve of abortion on demand, and had become convinced "too many abortions are too casually undertaken." I also stated that I had become convinced by reports, including an investigative account by the Philadelphia *Inquirer*, that a need existed to provide better protection for viable fetuses, particularly those aborted alive. Indeed, it is worth noting that even one of the most vocal legislative opponents of regulating abortion procedures acknowledged during recent floor debate on this bill that ". . . there is an abortion problem."

I believe that society has in obligation to provide certain basic protection for pregnant women contemplating or confronting the abortion process, particularly juveniles, and for a viable fetus which embodies human life. I believe that this interest of society in ensuring informed consent and protecting human health and life should be achieved with the minimum possible intrusion into the private lives of our citizens, and with the least possible interference in a decision-making process which should essentially be between a woman and her treating physician.

I recognize that both proponents and opponents of this bill have contended that it would limit or prohibit abortions. Even the original bill, with its excessive and objectionable provisions, would not in my view have prevented anyone intent upon obtaining an abortion from doing so. I believe that the provisions in the current bill address the legitimate interests of society in providing the basic protections I have referred to in a minimally intrusive -- and acceptable -- manner.

Under this bill, any abortion could be performed, prior to the viability of the fetus, if it is found to be medically or otherwise "necessary." The determination of necessity is left strictly to the judgment of a treating physician. The definition of "necessary" permits the physician to consider a wide array of criteria, including physical, emotional, psychological, and even familial factors and the age of the woman seeking the abortion. Under the necessity test as defined in this bill, it clearly appears that very few, if any, abortions which can now be performed under existing legal and medical standards would be prohibited. The necessity test as articulated in this bill is totaily consistent with the express language of the United States Supreme Court on this subject in *Doe vs. Bolton*.

This bill would impose a requirement that a woman contemplating abortion be counselled on all available options and the medical consequences of each. I believe this requirement to be reasonable for someone confronting a surgical procedure of this type and a personal decision of this magnitude -- one which studies show could have a lasting emotional impact. Indeed, I would think that any thoughtful and sensitive physician, under any circumstances, would agree that it is appropriate to apprise a patient of the various potential medical psychological and other risks and effects associated with such procedure. Further, I think it is right to

explain to a pregnant woman that there are alternatives to abortion if her only objection is raising the child or her only fear is the inability to support the child. An abortion that would not be performed but for ignorance or fear is perhaps an abortion best not performed.

It is important to note that, unlike the previous bill, this bill would not require physicians to personally provide all aspects of such counselling, but rather only those respecting medical matters. Other information and counselling may be provided, as is now practiced in responsible facilities, by knowledgeable counselors.

This bill would require a 24-hour "waiting period" between the counselling and the actual performance of an abortion. This period would provide a woman with an opportunity to assess and reflect upon this information. I believe this to be a reasonable requirement, particularly since this waiting period would not apply where a medical emergency compelled the performance of an abortion. Absent such medical need, I can foresee no harm arising from such a brief period of delay and reflection. Indeed, I would think that such a period of reflection is normal and reasonable whenever someone is evaluating and confronting surgical procedures that are even less imbued with stress and risk.

This bill would require minors and adjudged incompetents seeking an abortion to obtain the consent of a parent or guardian. In the alternative, such a pregnant woman could obtain a court order within a fixed brief time period, authorizing the performance of an abortion upon a finding either that the woman is mature and capable of giving her informed consent, or that the performance of an abortion would be in the woman's best interests. In such a proceeding, the pregnant woman would be entitled to free, court-appointed counsel, and all proceedings would be

kept confidential. In assessing the best interests of a minor seeking an abortion, I must assume that any court would rely heavily on the best medical judgment of the petitioner's physician. I continue to feel that this provision is reasonable and consistent with traditional and legal parental responsibilities for the welfare of their minor children, and with the traditional role the courts have played in determining the best interests of minor children. At no time is a minor more likely to need or stand to benefit from the guidance and support of a responsible adult than when facing the emotional trauma and dilemma of an unwanted pregnancy. Moreover, the justification for such guidance is certainly as compelling in the case of an abortion as that of current consent requirements for such comparatively routine surgical procedures as the removal of an appendix or tonsils.

This bill would require that any abortion after the first trimester of pregnancy be performed in a hospital, although not necessarily on an in-patient basis. Of all abortions performed last year in this state, 94.4 percent were performed during the first trimester. Abortions performed beyond that period are more likely to entail greater risks, complications and care. I believe this provision represents a reasonable and responsible precaution.

The bill would require certain precautions to help ensure the survival of an aborted fetus which was viable. Where a physician has determined prior to an abortion that the fetus is, in fact, viable, an abortion could only be performed upon a determination by the woman's physician that the abortion was necessary to preserve her life or health, and then, to the extent medically feasible, by the method most likely to preserve the viability of the fetus. I am advised that this is already the case pursuant to current normal medical practice.

The bill would require the presence of a second

physician to attend to the fetus should it be aborted alive. If a fetus is capable of living and growing outside the womb, it is difficult for me to accept that it does not embody a human life. If we are to regard ourselves as a humanitarian society, I believe that we must take every reasonable precaution in favor of the preservation of innocent life. I do believe these precautionary provisions to be reasonable and responsible.

While protecting the identities of individuals seeking abortions, physicians performing abortions, and those associated with facilities providing abortion, this bill does require that reports be filed with the state Health Department regarding abortions.

I believe that these reporting requirements are reasonable and could provide the kind of data that would be beneficial in enabling us to make more informed judgments about the continuing questions related to the matter of abortion. Indeed, 30 other states have enacted legislation with these types of reporting requirements.

Twenty-two other states have enacted laws comparable to Senate Bill 439, without evidence of the extreme effects predicted by both proponents and opponents of this measure.

I recognize that there is a legitimate difference of opinion, and, in some cases, a conflict among courts, over the constitutionality of some of these provisions -- most notably, the waiting period and parental consent requirements. While I believe firmly that issues such as this, which touch upon questions of life itself, must be resolved as a matter of conscience and conviction, I also recognize that, as Governor, I have an obligation to reject legislation which is patently unconstitutional. I do not, however, feel that I must undertake to resolve all possible Constitutional contentions in evaluating legislation. This is the province of the courts.

In this regard, I note that the U.S. Supreme Court

has agreed to review a number of lower court decisions on statutes related to abortion and thus to provide final and definitive judgments on the constitutionality of a number of state laws which encompass virtually all of the provisions in the measure now before me about which questions have been raised. The bill before me would not take effect for six months. Thus, it is highly likely that the Supreme Court will provide clear guidance for all the states in this area before this bill would take effect. Obviously, any provisions in this bill which are inconsistent with the determination about to be made by the Supreme Court could not and would not take effect.

With that understanding, and consistent with my convictions on this issue as explained in my message of December 23, 1981, I am herewith signing this bill.

/s/_____

Dick Thornburgh
Governor

Plaintiffs' Exhibit 62:
Veto Message to Pennsylvania House
of Representatives on H.B. 1130
of Governor Robert Casey
(Dec. 17, 1987)

December 17, 1987

TO THE HONORABLE THE HOUSE OF
REPRESENTATIVES OF THE COMMONWEALTH
OF PENNSYLVANIA

I am returning without my approval House Bill 1130, Printer's No. 2546, entitled "AN ACT amending Title 18 (Crimes and Offenses) of the Pennsylvania Consolidated Statutes, limiting the defense of justification in certain cases; PROVIDING FOR DISTRICT ATTORNEYS' STANDING AND INTEREST IN PRISONER LITIGATION; adding provisions relating to the establishment and operation of the Pennsylvania Commission on Sentencing; REGULATING MATTERS RELATING TO THE PERFORMANCE AND FUNDING OF ABORTIONS, THE PROTECTION OF WOMEN WHO UNDERGO ABORTION AND THEIR SPOUSES, AND THE PROTECTION OF CHILDREN SUBJECT TO ABORTION; increasing the penalties for false reports to law enforcement authorities; making an editorial change; and making repeals."

I was elected Governor of Pennsylvania to carry out the pledges I made to the people of this Commonwealth, and I will not break faith with those people, or break my promises to them. I have stated repeatedly that I am opposed to abortion on every moral ground. I believe that our society must not tolerate the destruction of

human life, and that we have a moral obligation to work to end this tragedy. This legislation, if corrected in the manner discussed below, will provide us with an opportunity to take a step forward in limiting this destruction.

In its present form, however, I have concluded that it is not constitutional and that I must veto it. But I strongly reaffirm today my commitment to joining with the clear majority of the Legislature who voted for this bill, and the majority of Pennsylvanians who voted for me on the basis of my clearly stated agenda for this state, to sign into law the strongest possible measure controlling abortion consistent with the Constitution and my oath to it.

There are two considerations that the gubernatorial role in the process compels me to interject into the legislation at this point. These two concerns intersect. The first is simply this: In order to ensure that the measures we adopt actually take effect and contribute to the reduction and someday, I hope, the elimination of abortions in our state, they must be not only well-intentioned but well-drafted and able to withstand the constitutional challenges that will be mounted against them.

The second consideration may be just as simply stated: I promised the people of Pennsylvania, and I took an oath, that I would uphold the Constitution. The legitimacy of our system of government, the finest on earth, depends not just upon our pursuit of the moral good, but also upon our adherence to the rule of law. Our law, and my oath as Governor, require that I execute those laws -- including the Constitution -- as interpreted by the courts, until such time as we are successful, through the democratic process, in changing the courts or the law they interpret.

These tasks are not ones that I take lightly. I would

do both the people, and the values I cherish and seek to promote, a grave disservice were I not to give them my fullest attention and care. Given the magnitude of the issue, and its importance to so many Pennsylvanians, I have taken it as a solemn duty to review this matter, and the state of the law, in considerable depth. The adoption of concrete, final language by the Legislature enabled me, beginning last week, to undertake a comprehensive study of that language and the United States Supreme Court's rulings on the subject of abortion. I have wrestled continuously over the past few days with each of the questions potentially raised by the state of the law and its application to this bill. It is only after this searching analysis that I am ready to discuss this legislation fully with the Legislature and the people of this state.

A few sections of the bill call for our particular attention. The first of these is the informed consent provision that would be included in Section 3205 of the new law. The United States Supreme Court has ruled that a state cannot prohibit a physician from delegating to another qualified individual the counseling task in the informed consent context. The wording of the proposed Section 3205 is, however, potentially ambiguous on that point, and may possibly be read by some as requiring that counseling be carried out *only* by the performing or referring physician.

I do not believe that the legislation suffers from such a constitutional defect, however. When read *in pari materia* with the Medical Practice Act of 1985 governing all medical procedures in the Commonwealth, it is clear that, absent an express legislative declaration otherwise, physicians may delegate the functions in question to individuals qualified to perform such counseling. A statute is to be read so as to render it constitutional, and with such a reading Section 3205 is constitutional. I

therefore believe that this section of the bill must be so construed and thus passes constitutional muster.

Section 3209 requires that, except as provided in that section, before an abortion may be performed the woman must verify that she has notified the child's father of her decision to seek an abortion. To the extent that our law continues to allow the termination of the procreative process once set in motion, a decent society ought to do everything possible to promote participation and prudence in that decision by both the mother and father.

The Supreme Court has consistently adhered to a legal framework established in *Roe v. Wade*, and which may be summarized as follows: The right to obtain an abortion is derived from the right of privacy. This right of privacy protects various facets of an individual's life against government intervention and surveillance. While some of the concerns that give rise to this right of privacy grow out of such contexts as marriage, procreation, family relationships, and child-rearing -- all of which involve more than one individual -- the right of privacy is an individual right, accruing to each and every person individually and beyond the reach of the state. It was on this basis that the Court struck down a requirement that a woman obtain her spouse's consent before she could undergo an abortion.

Other rulings by the Court have declared that a state may not compel disclosure of information protected by an individual's right of privacy to *any* third-party; that a state lacks a legally justifiable interest in simply knowing the identity of a woman seeking an abortion; and that a state cannot intervene in the marital relationship to dictate the relations between husband and wife. In striking down spousal consent requirements, the Court held that a state cannot delegate to any third-party -- even a husband -- a power that the state cannot exercise

itself.

Moreover, in the one context in which the Court *has* upheld the involvement of others in an individual abortion decision -- parental consent and notice laws regulating minors seeking abortions -- the Court has permitted states to require such involvement only as a mature substitute for an immature minor's decision. The Court has mandated that a mature minor must be able to pursue an abortion without parental consent, or even notice. The case law makes plain that the Court treats consent and notice requirements equivalently in regard to their impingement upon the individual exercise of the abortion decision to which the Court has extended privacy protection.

I strongly disagree with this reasoning as a matter of morality, wisdom, and constitutional interpretation. My duty, however, requires me to pursue our objectives within the Constitution. The Supreme Court's decisions make it clear that the paternal notice requirement will be struck down as unconstitutional if enacted. Moreover, every state statute requiring merely *spousal* notice that has been taken before a federal court has been struck down. I am forced to conclude that this provision poses the almost certain and unacceptable prospect of invalidation, and costly, unsuccessful, and avoidable litigation.

In addition, Section 3214, which requires the reporting of information to the Department of Health, remains substantially unchanged from the version summarily struck down by the Supreme Court less than two years ago. The Court has indicated that the government has a sustainable interest in the collection of health-related data in the abortion control context. However, where information concerning identifiable individuals is maintained by the government, sufficient safeguards against its release must exist under the law;

the government must, of course, have a legitimate health-related concern for knowing the specific identity of the individuals to whom that data pertains. In its *Thornburgh* decision striking down this Section, the Court explicitly found substantial portions of the data required under the Act not to be health-related and therefore to be constitutionally infirm.

While eliminating the public copying provision that the Court struck down, the bill as drafted neither provides the types of confidentiality safeguards required and which are utilized for other sensitive health data, nor excludes any of the data -- such as method of payment, the woman's personal history, and the bases for medical judgment -- that the Court specifically singled out as unwarranted. In that light, the provision unnecessarily invites invalidation and would not represent responsible legislation.

Finally, I must note that our concerns cannot end with protecting unborn children, but must extend to protecting, and promoting the health, of *all* our children, and their mothers. The right to life must mean the right to a decent life. Our concern for future mothers must include a concern for current mothers. Our respect for the wonders of pregnancy must be equaled by a sensitivity to the traumas of pregnancy. This Administration has called for significantly increased support for child and maternal health programs, for education, for rape counseling and support services. And we will continue to advance more programs born of the recognition that our moral responsibility to mothers and children does not end at birth. Those proposals deserve to receive the same overwhelming vote of approval in the Legislature that this bill received.

Let me restate in summary the distinction between personal belief and constitutional duty as it applies to this legislation. I believe abortion to be the ultimate

violence. I believe strongly that *Roe v. Wade* was incorrectly decided as a matter of law and represents a national public policy both divisive and destructive. It has unleashed a tidal wave that has swept away the lives of millions of defenseless, innocent unborn children. In according the woman's right of privacy in the abortion decision both exclusivity and finality, the Supreme Court has not only disregarded the right of the unborn child to life itself, but has deprived parents, spouses, and the state of the right to participate in a decision in which they all have a vital interest. This interest ought to be protected, rather than denied, by the law. This policy has had, and will continue to have, a profoundly destructive effect upon the fabric of American life. But these personal beliefs must yield to the duty, imposed by my oath of office, to follow the Constitution as interpreted by the Supreme Court of the United States.

In light of these conclusions imposed upon me by my oath and obligation as Governor, I am returning this bill to the Legislature without my signature, for revision along the lines indicated. Most importantly, I emphasize again that we must -- and we will -- enact a strong and sustainable Abortion Control Act that forms a humane and constitutional foundation for our efforts to ensure that no child is denied his or her chance to walk in the sun and make the most out of life. I will sign this bill when it reaches the end of the legislative process and attains those standards.

/s/ _____
Robert Casey
Governor

Plaintiffs' Exhibit 67:
Excerpts from *The Federal Role in Determining the Medical and Psychological Impact of Abortion on Women*,
H.R. Rep. No. 392, 101st Cong., 1st Sess. (1989)

THE FEDERAL ROLE IN DETERMINING THE MEDICAL AND PSYCHOLOGICAL IMPACT OF ABORTION ON WOMEN

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[6] Although CDC researchers have concluded that abortion is generally safe, Dr. Willard Cates, Jr., and Dr. David Grimes, both former directors of the CDC Abortion Surveillance Branch, have re[7]ported that the earlier an abortion is performed, the safer it is for the woman.[31] For example, Dr. Cates and Dr. Grimes reported that the risk of death to the pregnant woman obtaining an abortion doubles for every two weeks' delay after eight weeks of gestation.[32] However, they concluded that "once pregnant, a woman encounters an increased risk of death, no matter what her choice of outcomes," and that before 16 weeks gestation, legal abortion is safer than any other alternative outcomes.[33]

In concluding that abortion does not cause long-term

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[31] Cates, W., Jr. and Grimes, D.A. (1981). Morbidity and Mortality of Abortion in the United States, in Hodgson, J.E. (Ed.) *Abortion and Sterilization: Medical and Social Aspects*. London: Academic Press Inc., p. 158; in subcommittee files.

[32] Ibid., p. 171.

[33] Ibid., p. 170.

health problems, the Surgeon General's draft report apparently rejected the medical reports that linked abortion to later reproductive hazards. Similarly, CDC researchers have criticized some of the research presented as evidence of medical problems resulting from abortion as having obvious methodological flaws.[34] For example, the National Right-to-Life Committee presented the subcommittee with a chapter written by Matthew J. Bulfin from *New Perspectives on Human Abortion* as evidence of the dangers of abortion.[35] In the chapter, Dr. Bulfin, a physician in private practice, documented the number of patients who came to him with infections, anxiety, and other problems resulting from a prior abortion. He concluded that 159 (20 percent) of 802 abortion patients that he saw had suffered from serious complications (including marital break-up).

CDC researchers have stated that it is not scientifically appropriate to assume that these kind of statistics are representative of abortion patients, since Dr. Bulfin's patients apparently came to see him because they had medical problems.[36] The weakness of these statistics is that they do not compare the number of abortion patients with problems to the total number of women who have had abortions. Therefore, when a

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[34] Cates, W., Jr. (1979). Late effects of induced abortion, *Journal of Reproductive Medicine*, Vol. 22, pp. 207-212.

[35] Bulfin, M.J. (1981). Complications of Legal Abortion: A Perspective From Private Practice, in Hilgers, T.W., Horan, D.J., and Mall, D. Frederick, MD: Altheia Books, pp. 145-150; available in subcommittee files.

[36] This kind of research was criticized in: Cates, W., Jr. (1979). Late effects of induced abortion: Hypothesis or knowledge? *Journal of Reproductive Medicine*, Vol. 22, pp. 207-212.

study is based on patients seeking treatment in one doctor's office, it is considered anecdotal data, rather than scientific research. Dr. Koop rejected anecdotal evidence as unscientific in his review of the medical evidence.[37] Moreover, studies reported in book chapters, such as Dr. Bulfin's, are not peer reviewed by scientists, and are therefore not considered scientific evidence.[38]

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[10] In their review paper presented to the Surgeon General, the American Psychological Association concluded that, despite the flaws in the research, there is so little evidence of psychiatric problems following abortion, and so much evidence of relief, that therefore abortion does not cause more psychiatric problems than unwanted pregnancy.[53] They also argued that given the large number of abortions, any significant psychiatric problems would have become very obvious to the mental health system in the last 15 years.[54] Dr. Henry David, who represented the American Public Health Association in his meetings with Dr. Koop and in his Congressional testimony, acknowledged that some women have psychiatric problems following abortion. However, his research

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[37] Hearing, testimony of Dr. C. Everett Koop, p. 232.

[38] Hearing, testimony of Dr. Jaroslav F. Hulka, pp. 3, p. 331.

[53] *Testimony on the Psychological Sequelae of abortion*, on behalf of the Public Interest Directorate of the American Psychological Association, presented to the Office of the U.S. Surgeon General, December 2, 1987, pp. 25, 29; document available in subcommittee files.

[54] Ibid. p. 3.

results indicate that the numbers are small, and there is no conclusive evidence that those psychiatric problems necessarily resulted from the abortion itself, rather than from the breakup of the relationship (which resulted in the unwanted pregnancy) or other factors.[55]

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[11] The National Right-to-Life Committee "white paper" also summarized the psychological research and concluded that the evidence was unclear but possibly showed more negative effects for abortion compared to maintaining the pregnancy.

One major study quoted by both the pro-choice advocates and the anti-abortion advocates helps illustrate the controversies. Dr. Henry David conducted a study of more than one million women in Denmark, to determine whether women who had obtained abortions 3 months earlier were more likely to be treated in psychiatric hospitals than were women who have given birth 3 months earlier or women who had not been pregnant.

Dr. David's research was cited as one of the best studies of the psychiatric impact of abortion by the Right-to-Life white paper and by pro-choice advocates.[62] Dr. David reported that approximately 12 women per 10,000 abortions or deliveries were hospitalized, compared to 7 per 10,000 for all women of reproductive age. He also reported that separated, divorced, or widowed women who obtained abortions were much more likely to be hospitalized in a psychiatric facility than divorced, separated or widowed women who give birth, perhaps because it "may have been an

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[55] Hearing, testimony of Dr. Henry David, p. 144.

[62] Hearing, testimony of Dr. Wanda Franz, p. 144.

originally wanted pregnancy."[63]

In contrast, the Right-to-Life white paper misrepresented this study, quoting statistics for divorced, separated, and widowed women having abortions (63.8 per 10,000) as if they applied to all women having abortions. When asked to explain this error or misrepresentation, Dr. Wanda Franz, vice president of the National Right-to-Life Committee, testified "The issue here is that the direction of the findings are that those women who had abortions had higher rates" and speculated that the abortion decision may have caused the breakup of the relationship.[64] She did not answer the question of why the psychiatric rates that applied to the less than 10 percent of the women who were divorced, separated, or widowed were incorrectly cited as if they applied to all of the more than 27,000 women who had obtained abortions.[65]

The major focus of the "white paper" was a meta-analysis, which is a statistical comparison that includes the data from several previously conducted research studies. The white paper was the one [12] new research paper for which Dr. Koop and his staff requested detailed criticisms. The paper was vehemently criticized by CDC scientists and other researchers who were asked to review the quality of their scientific evidence. For example, scientists at the Center for Health Promotion and Disease Prevention at CDC reported the following

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[63] Hearing, testimony of Dr. Henry David, p. 97.

[64] Hearing, testimony of Dr. Wanda Franz, pp. 144-145.

[65] The statistics are clearly presented in the published article, which was reviewed by the Surgeon General and his staff: David, H.P., Rasmussen, N.K., and Holst, E. (1981). Postpartum and postabortion psychotic reactions, *Family Planning Perspectives*, Vol. 13, pp. 88-93.

problems with the meta-analysis:

"1. The authors combine outcomes that are not well defined and are probably not comparable;

"2. The comparison groups used in the studies that were analyzed are inappropriate;

"3. The analysis was based on studies that, according to the authors of the report, are largely flawed as to design and methodology; and,

"4. The authors' assumption[s] . . . cannot be justified from the data."

The CDC scientists concluded that "Since the meta-analysis used a combination of studies with disparate results, the conclusions based on such analysis have little value."[66]

Scientists from the National Center for Health Statistics who were asked to review the white paper for the Surgeon General concluded that "the meta-analysis has no value" and that "The conclusions drawn by the authors seem to be based on a priori beliefs rather than on objective review of the evidence."[67]

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[14] For example, in his meeting with the American Council on Science and Health, Dr. Koop stated ". . . there is no doubt in my mind that there are physical effects of abortion and mental effects of abortion. They are, I think, a very tiny percentage of the number of people that are aborted. . . . I don't think there is any way that one could do an honest report and come up with such overwhelming statistics that you could use it as

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[66] This review document is in Hearing, pp. 151-155.

[67] Hearing, p. 156.

a weapon against abortion itself."[83] Similarly, in his meeting with the National Organization of Episcopalians for Life, he stated "The problems that truly present health problems are someplace down here. They're quite minuscule."[84]

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[83] Transcript of meeting of Dr. C. Everett Koop with the American Council on Science and Health, February 4, 1988, p. 7.

[84] Transcript of Dr. C. Everett Koop's meeting with the National Organization of Episcopalians for Life, March 31, 1988, p. 8; available in subcommittee files.

Plaintiffs' Exhibit 89:
Diagnostic Criteria for
Post-Traumatic Stress Disorder

A. The person has experienced an event that is outside the range of usual human experience and that would be markedly distressing to almost anyone, e.g., serious threat to one's life or physical integrity; serious threat or harm to one's children, spouse, or other close relatives and friends; sudden destruction of one's home or community; or seeing another person who has recently been, or is being, seriously injured or killed as the result of an accident or physical violence.

B. The traumatic event is persistently reexperienced in at least one of the following ways:
   (1) recurrent and intrusive distressing recollections of the event (in young children, repetitive play in which themes or aspects of the trauma are expressed)
   (2) recurrent distressing dreams of the event
   (3) sudden acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative [flashback] episodes, even those that occur upon awakening or when intoxicated)
   (4) intense psychological distress at exposure to events that symbolize or resemble an aspect of the traumatic event, including anniversaries of the trauma

C. Persistent avoidance of stimuli associated with the trauma or numbing of general responsiveness (not present before the trauma), as indicated by at least three of the following:
   (1) efforts to avoid thoughts or feelings associated with the trauma

   (2) efforts to avoid activities or situations that arouse recollections of the trauma
   (3) inability to recall an important aspect of the trauma (psychogenic amnesia)
   (4) markedly diminished interest in significant activities (in young children, loss of recently acquired developmental skills such as toilet training or language skills)
   (5) feeling of detachment or estrangement from others
   (6) restricted range of affect, e.g., unable to have loving feelings
   (7) sense of a foreshortened future, e.g., does not expect to have a career, marriage, or children, or a long life

D. Persistent symptoms of increased arousal (not present before the trauma), as indicated by at least two of the following:
   (1) difficulty falling or staying asleep
   (2) irritability or outbursts of anger
   (3) difficulty concentrating
   (4) hypervigilance
   (5) exaggerated startle response
   (6) physiologic reactivity upon exposure to events that symbolize or resemble an aspect of the traumatic event (e.g., a woman who was raped in an elevator breaks out in a sweat when entering any elevator)

E. Duration of the disturbance (symptoms in B, C, and D) of at least one month.

Specify delayed onset if the onset of symptoms was at least six months after the trauma.

EXCERPTS FROM VERIFICATIONS FILED IN SUPPORT OF PLAINTIFFS' PRELIMINARY INJUNCTION MOTION

Excerpts from Verification of Sue Roselle (Apr. 18, 1988)

VERIFICATION OF SUE ROSELLE

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6. WHS provides approximately 11,800 free pregnancy tests and 7,600 first and early second trimester abortions each year. The abortion procedure costs as follows: $275 if twelve weeks or less from the last menstrual period; $375 if thirteen to fourteen weeks from the last menstrual period; and $500 if fifteen to sixteen weeks from the last menstrual period. The fee includes the abortion procedure, laboratory testing, personal counseling including contraceptive care, pathological examination and medical supervision during the post-surgical recovery period.

7. If our clients are eligible for medical assistance, WHS takes the necessary information and seeks reimbursement from the Commonwealth. Medical assistance is available only where the abortion is necessary because of a life-threatening condition, or because the patient was a victim of rape or incest. In 1987, WHS was reimbursed for 249 such abortions. Where a client receives medical assistance from the state, but is not eligible for medical assistance for an abortion, WHS nevertheless will discount the cost of the abortion. Last year WHS accomodated 1,470 clients who were unable to pay the full amount. WHS has never turned away any client seeking an abortion merely because of inability to pay.

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9. Our patients come primarily from Allegheny County. In 1987, however, 761 of our abortion patients came from areas in excess of two hours traveling time (100 miles) from the clinic.

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11. When they present themselves at the clinic, if indicated, women are examined by a nurse practitioner or physician's assistant and everyone receives a pregnancy test and blood tests. In addition, all women are required to have an individual interview with a counselor on the day their abortion is to be performed. These interviews routinely last twenty minutes to an hour. During this interview, a woman is counseled with respect to her options and her decision to have an abortion. In that connection, the counselor seeks to ensure that the woman is not unduly ambivalent about her decision and that she is not being coerced. In addition, the counselor discusses future contraceptive use with the patient. If the patient appears ambivalent about her decision, the counselor will refer her to one of our staff therapists and the abortion will be rescheduled to give the patient more time to consider her options. On occasion, the clinic will refuse to perform the abortion if convinced of a patient's continued ambivalence. This is rare, however, because the great majority of our patients have absolutely decided to have an abortion before seeking medical care.

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20. In general, WHS supports and encourages parental involvment in the abortion decision where

possible.

21. Under Section 3206, WHS will require the presence of a parent in order to give counseling to that parent sufficient to assure the parent is able to give his or her informed consent. We foresee no circumstances in which we would secure parental informed consent over the telephone, by mail, or means other than by an in-person visit to our clinic. This, in turn, may cause serious delays in the abortion even in cases where the parent is prepared to consent. Many parents will find it difficult to come to the clinic for the necessary counseling because of their work schedules, illness or other commitments.

22. The implementation of the parental consent requirement will cause administrative and scheduling nightmares inasmuch as at present, we normally do parental counseling on the day of the abortion procedure, which are performed only three days a week.

* * *

24. Some parents may not be able to come to the clinic for many days, or possibly even weeks, after their minor daughter has decided to seek an abortion. This would be true even in cases where the parent fully consents to the minor's having an abortion. The resulting delay caused by this could be both dangerous and prohibitive since most minors decide to have an abortion much later in their pregnancies than adults.

25. The additional costs incurred for minors and their parents who must come long distances -- whether together or separately -- could also be extremely burdensome and may result in the minor's effectively being deprived of her right to have an abortion.

26. Another problem with Section 3206 is that it does not state what procedures and documentation are

necessary for obtaining legally valid parental consent. Thus, because this section is so vague and uncertain, WHS will have to be extremely conservative in deciding on the kind of identification that will be required from the parent, resulting in further delay of the abortion procedure. If the parent does not have the proper documentation of parentage, the abortion would have to be rescheduled.

27. WHS also is greatly concerned about the effect the parental consent and judicial bypass provisions will have on minors themselves. Adolescents as a group are reluctant to establish contact with unfamiliar organizations. It is a difficult enough chore to call the clinic. The additional burden of being forced to go to a parent when reluctant to face a court may have one of several disastrous results for the adolescent: (a) the teen will come in later for her abortion because of the greater time it will take her to resolve the higher level of fear and confusion created by the legal requirements. The later she has an abortion, the more likely she is to have complications; (b) the teen will tell no one until the pregnancy is so advanced that someone else finally confronts her. The parents and teen may then have no options because the advanced stage of the pregnancy at this time precludes an abortion; (c) the teen will attempt a self-induced or illegal abortion with resulting permanent damage to her reproductive system or death; (d) the teen will run away from home; or (e) the situation will be deemed unresolvable by the teen and suicide will be viewed as the only escape. (Adolescents have been documented to have one of the highest suicide rates of any segment of the population).

28. Sections 3207(b) and 3214(f) will require WHS, respectively, to file annual reports identifying our facility and quarterly reports showing the total number of abortions performed per trimester of pregnancy. Under

the Act, these reports, if filed by facilities receiving any state-appropriated funds, will be open to public inspection.

29. WHS does receive state-appropriated funds in the form of state medical assistance funding for the victims of rape and incest and for patients whose pregnancy must be terminated because of physical conditions that are life-threatening. Additionally, WHS receives federal funds that are appropriated by the state for the purpose of counseling and testing clients who are in high risk groups for exposure to the Human Immunodeficiency Virus (HIV), the precursor of AIDS.

30. Inasmuch as WHS does receive state-appropriated funds, we are extremely troubled that our reports will be open for public inspection and copying. Over the years, WHS has been the target of continued harassment and violence by anti-abortion groups. On many occasions we have discovered anti-abortion advocates going through our trash to find any scraps of information they might put to use. Public disclosure of the information filed in the reports required by the Act is certain to enhance the frequency and intensity of the harassment and violence. In turn, women will be further intimidated from using our clinic for fear of being subjected to verbal and physical abuse. The intimidation deters all of our clients, and not just those pursuing their legal right to have an abortion. Many women intending to have an abortion in our clinic have also told me of their fear that the procedure itself will be interrupted by demonstrations, bomb scares and similar activities. Finally, such anti-abortion activities adversely effect the ability of WHS to operate its business and offer its services to the public.

31. In addition, Sections 3207(b) and 3214(f) provide that confidentiality of the required reports is conditioned upon whether a facility has received state-appropriated

funds within the 12-month period preceding the filing of the report. The retroactivity of this provision is disturbing to WHS because, at least with respect to reports we must file during the coming year, we have been deprived of a choice of whether to protect the confidentiality of our records no longer accepting state-appropriated funds. In 1987, WHS received medical assistance reimbursement for the treatment of only 249 patients. Had we known that receipt of such a relatively small amount of money would threaten the confidentiality of WHS records, we may well have decided to discontinue accepting medical assistance. Similarly, it was only in March of 1988 that WHS contracted for state-appropriated federal funding of HIV testing and counseling. Before that time WHS had been offering HIV testing and counseling for a small fee. Had we known of the confidentiality implications of our accepting the federal funds, we may have decided not to enter into the contract.

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34. The identification of facilities in Department reports is certain to open the door to increasing anti-abortion harassment and violence. In addition, some of the information that is required to be reported, coupled with the Department's right to identify facilities, exacerbates the risk. For example, under 3214(h), all physicians are required to report complications that they judge to have resulted from an abortion or attempted abortion. The definition of "complication" is vague; and the reporting requirment could permit physicians to exploit, abuse, or even inadvertently misconstrue the complications reporting procedure to the derogation of facilities such as WHS.

35. The second grave risk of section 3214 is the risk

posed by the requirement that the names of all referring and performing physicians must be reported to the Department. I can state with complete certainty that because of the harassment and violence directed toward physicians who refer or perform abortions procedures, WHS will lose many of its referring physicians and possibly some of its performing physicians if this section goes into effect.

36. Many of our referring physicians in particular, are extremely protective of their anonymity because of legitimate fears (often based on past experience) that any kind of documentation or record-keeping connecting them with any phase of the abortion decision could cause them to lose their medical practice, hospital and other professional privileges, as well as the ability to reside in their communities peacefully and without harassment.

37. For example, I personally know two medical doctors who, although they do not perform abortions, do refer clients to WHS for abortions on the strict condition that we not use their names in any WHS reports. They insist upon this because in the past, each has been subjected to public abuse, picketing and pamphleteering based on their having performed or referred abortions during their medical residencies. Each of these doctors has told me emphatically that under no circumstances would he refer any abortions to WHS or any other clinic under the new Act -- even if there were no risk of public disclosure at all. The mere requirement that their names appear on reports filed with a Commonwealth agency is sufficient, based on their past experience, to deter them from making any future referrals.

38. The net effect of this will be that women will be unable to find physicians willing to refer or to perform abortions for them, which in turn, operates to deny them their right to choose to have an abortion.

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Excerpts from Verification of Sylvia Stengle (Apr. 18, 1988)

VERIFICATION OF SYLVIA STENGLE

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7. For patients who receive medical assistance from the Commonwealth, AWC's fee for an abortion is $195. In the case of those medical assistance patients who require an abortion because of a life-threatening disease or because they were victims of rape or incest, AWC -- in the past -- has received reimbursement from the state, so that no fee was charged directly to the patient. The amount involved is relatively small. In 1987, AWC received less than $4,000 in medical assistance funds.

8. With the passage of this Act, AWC has decided to stop taking medical assistance funds from the state immediately.

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10. Our patients come primarily-from an 18-county area in northeastern Pennsylvania encompassing the counties of Lehigh, Northampton, Carbon, Schuylkill, Luzerne, Lackawanna, Lebanon, Berks, Bucks, Pike, Chester, Lancaster, Susquehanna, Wayne, Monroe, Montgomery, Columbia and Wyoming. Many of these counties have no local services available to women seeking abortions, AWC being the closest facility to which the women can turn. In 1987, 138 (3.26%) of our abortion patients came from areas in excess of two hours traveling time (100 miles) from the clinic; 1,220 or 29% came from areas in excess of 1½ hours traveling time (75 miles); and 2,276 or 54% came from areas in excess of 1

hour traveling time (50 miles).

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17. If the patient appears ambivalent about her decision to have an abortion, the counselor will review options and suggest that the patient take more time to consider her decision before terminating the pregnancy. On occasion, the clinic has refused to permit an abortion if, after consultation, the counselor and the clinic supervisor are convinced of the woman's extreme ambivalence, coercion, or that she is otherwise overly distraught. Sometimes, we will refer these women to outside counselors. Such instances are infrequent, however, because the great majority of our patients have absolutely decided to have an abortion before making an appointment here.

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24. Section 3206 requires that in order for a minor who is less than 18 years old and not emancipated to obtain an abortion, either one parent must give his or her informed consent to the abortion, or the minor must go through a judicial bypass procedure. This is certain to cause dangerous delays which could effectively deprive many minors of their right to have an abortion. Often, minors are overwhelmed by the prospect of involving parents because of fears of retaliation or rejection by the parents. Even where parents are involved and willing to consent, they may have scheduling problems making it difficult for them to come to the clinic.

25. Under the parental consent provision of the Act, AWC will have to insist upon a personal visit to the clinic by a parent so that we can give the counseling necessary to assure that the parent's (and minor's)

consent is informed. Normally, we will want the parent and daughter to come together for counseling, although this will not always be possible.

26. Requiring a consenting parent to come to the clinic for counseling and consent will most certainly cause serious delays -- even in cases where a parent is willing to consent. Many parents will find it difficult to visit the clinic because of work schedules, illness, burdensome travel distances and costs, or other commitments.

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28. Some parents may not be able to get to the clinic for days, even weeks, after the daughter has decided to seek an abortion. Ensuing delays could be both dangerous and prohibitive since it is well-documented that minors as a group decide to have abortions much later in their pregnancies than do adults.

29. The likelihood of dangerous delay is particularly great in our part of the state because AWC services such a large (18-county) area. Furthermore, travel time and costs for minors and their parents will surely increase in cases where the parent and minor will not be able to come for joint counseling on the day of the procedure, the delay and costs will be even greater.

30. An antecedent, and perhaps more serious delay arises from the minor's fear and hesitation in divulging to her parents that: first, she has been sexually active; second, that she is pregant; and third; that she wishes to have an abortion. The prospect of the disruption and trauma erupting from such disclosure may cause the minor to delay telling her parents for days and even weeks. It is well-known that the risk of complications from an abortion increase dramatically with each day's delay, particularly after the 10 to 12 weeks gestation period.

31. Another disturbing aspect of 3206 is that it does not state what procedures and documentation are necessary for obtaining legally valid parental consent. This vagueness leaves AWC uncertain as to what we must require. We are concerned that no matter what identification procedures we adopt, we may be subject to civil liability. We are even more concerned about the penalties to our physicians who may be subject to suspension or revocation of their medical licenses. In any event, because the Act fails to provide guidance, we will be forced to implement stringent documentation requirements which, in turn, will cause further delays in the abortion procedure.

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34. Second trimester abortions involve far more risks of complications than earlier abortions, and each passing day enhances these risks. At some point, the minor will suddenly find herself with no options and be forced to continue the pregnancy. Some will respond by trying to obtain illegal abortions or by attempting to self-induce an abortion. Others may resort to suicide. Problem pregnancy is a leading cause of suicide among adolescent women. In the past, AWC has had to do suicide counseling with pregnant minors. The new Act will only exacerbate the trauma and risks for these young women.

35. AWC is also troubled by sections 3207(b) and 3214(f) of the Act. Under these sections, AWC's annual reports (identifying our facility and its affiliates) and quarterly reports (stating the total number of abortions performed per trimester of pregnancy) to the Department of Health will be open for public inspection and copying as long as AWC receives state-appropriated funds.

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37. During the past 12 months, AWC has received stateappropriated funds in the form of reimbursements for services to patients who are under state medical assistance. We are therefore extremely concerned about the prospect of our reports having no confidentiality. Over the years, AWC has been the target of continued harassment and threats of violence by anti-abortion groups. These groups are eager to obtain as much information as possible to fuel their activities. Public disclosure of the information filed in the reports is certain to intensify their activities. Women, in turn, will be even more intimidated from using our clinic for fear of being subject to verbal or even physical abuse. Too, anti-abortion harassment severely cripples AWC's ability to operate the clinic and offer its services to the public. Had we known that receipt of a relatively small amount of state funds would compromise the confidentiality of AWC's records, we could have decided to discontinue accepting state medical assistance as a means of containing the level of harassment we now endure.

38. As to the future, AWC has decided that with the enactment of the Act, it will terminate immediately all receipt of state-appropriated funding so that in 12 months time, the confidentiality of our records can be protected. This will mean that AWC will have to insist that patients who are on medical assistance must pay for our services or else be turned away. Thus, in the final analysis, it will be poverty-level women who will be the real victims of the Act.

39. AWC also finds it sadly ironic that while on the one hand, the Commonwealth reimburses the cost of abortions for medical assistance patients who were victims of rape, incest or have life-threatening conditions, and on the other, it penalizes providers of those abortions by depriving them of the right of confidentiality over their records.

40. Section 3214(a) sets out additional reporting requirements including, among other things, identification of all physicians who refer for, or perform abortions, and the reporting of complications that may have resulted from an abortion or attempted abortion. In addition, Section 3214(e) permits the Department of Health to issue an annual report based upon this information, and provides only that the report shall not lead to the disclosure of the identity of any person filing a report or about whom the report is filed.

41. These two provisions seriously threaten the availability of referring and performing physicians to AWC, and therefore affect its ability to continue providing services to our patients. Many of our physicians are highly protective of their anonymity because of legitimate fears of anti-abortion activities. Many physicians who would otherwise work for AWC, will not because of legitimate fears of anti-abortion harassment, picketing and violence. Likewise, referring physicians have told me that any kind of documentation -- even if only state-filed reports not open to the public -- connecting them with any aspect of the abortion decision could cause them to be subject to harassment in the communities in which they reside.

42. For example, several of AWC's present referring physicians will not permit us to send correspondence to their offices for fear that members of their own staffs will divulge to anti-abortion groups that they refer patients for abortions. One has told me that the new record-keeping provisions of 3214 would mean that many doctors will stop referring for abortions altogether. Thus, patients coming to these doctors for help would have to go elsewhere for information about AWC or similar facilities, even though the information is at the doctors' fingertips.

43. Another doctor who has performed abortions for

AWC in the past has told me that in light of the new Act, he would not consider working for the clinic any longer for fear of public exposure and harrassment. At one time, this doctor had performed abortions in his private practice but stopped doing so after receiving threats that anti-abortionists would begin picketing his home.

44. A third doctor with whom I have spoken, and who also stopped performing abortions because of threats from anti-abortionists, has told me that he too would be unwilling to refer patients to AWC for fear of reprisal and harassment. He also told me that he believes the hospitals, in order to preserve the confidentiality of their records, will stop performing abortions, and that private doctors who perform abortions will stop accepting patients on state medical assistance. This will have serious repercussions for many women on medical assistance.

45. For example, women with serious health problems cannot normally go to a clinic to have an abortion. Rather, they would have to go to a hospital for the procedure. If the woman is on public assistance, however, and the doctor and/or hospital refuse to perform her abortion, the woman will have no options whatsoever -- other than to lie about her physical condition so as to secure an abortion at a clinic (and thereby take the risk of serious medical complications). These women will be effectively and wholly deprived of their right to choose to have an abortion.

46. In my opinion, the sole purpose of the Act's various reporting requirements, along with the attendant risks of public disclosure of certain information in these reports, is to harass and deter physicians and clinics.

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